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Rose

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

In ch. Etc

X Roland

Stearns

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Hunt

Percival

Symes

Labov

Transcript of evidence  
for

September 20, 1983

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.


Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Tuesday, the 20th  
day of September, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

E. CRONK	Commission Counsel
T.C. MARSHALL, Q.C.) D. HUNT )	Counsel for the Attorney- General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.J. ROLAND) R. BATTY ) M. THOMSON )	Counsel for The Hospital for Sick Children
B.A. PERCIVAL, Q.C.) D. YOUNG )	Counsel for The Metropolitan Toronto Police
W.N. ORTVED) K. CHOWN )	Counsel for numerous Doctors at The Hospital for Sick Children
B. SYMES	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd)



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APPEARANCES: (Continued)

H. SOLOMON	Counsel for the Ontario Association for Registered Nursing Assistants
D. BROWN	Counsel for Susan Nelles - Nurse
G.R. STRATHY	Counsel for Phyllis Trayner - Nurse
B. JACKMAN	Counsel for Mrs. M. Christie - R.N.A.
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of Amber Dawson)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)





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A/EMT/ak

1  
2 ---Upon commencing at 10:00 a.m.

3 THE COMMISSIONER: Yes, Miss Cronk.

4 MS. CRONK: Good morning, sir. Our  
5 next witness is Dr. Vera Rose from the Hospital for  
6 Sick Children.

7 THE COMMISSIONER: Thank you.

8 MS. CRONK: Dr. Rose?

9 DR. VERA ROSE, Sworn

10 DIRECT EXAMINATION BY MS. CRONK:

11 Q. Dr. Rose, as I understand it,  
12 you obtained your Bachelor of Science general degree  
13 at the University of London, England, 1947; is that  
14 correct?

15 A. That is correct.

16 Q. In the following year, your  
17 Bachelor of Science speciality degree you obtained in  
18 physiology at the same University?

19 A. Yes.

20 Q. And as I understand it you  
21 obtained your Bachelor of Medicine in 1953 from the  
22 University of London?

23 A. Yes.

24 Q. You joined the Hospital for  
25 Sick Children as assistant resident physician in  
January of 1955, and as I understand it have been







1  
2 affiliated with the Division of Cardiology ever  
3 since.

4 A. That is not quite correct.

5 Q. All right.

6 A. I have been affiliated with  
7 the Division of Cardiology since the late fifties.

8 Q. Since the late fifties? Did  
9 you do your assistant residency at the Hosiptal in  
10 1955?

11 A. Six months of it.

12 Q. Thank you. And then you did  
13 your fellowship, as I understand, in pediatrics here  
14 in Toronto, and as well were a research fellow with  
15 the Department of Cardiology at the Hospital for  
16 Sick Children in the early 1960s.

17 A. Yes.

18 Q. And in the years 1964 to 1968,  
19 as I understand it, you were the cardiologist in  
20 charge of what has been described to me as the  
21 computer system for cardiac records and evaluation  
22 for the Division of Cardiology at the Hospital. Is  
23 that correct?

24 A. That is correct, yes. And I  
25 still am.

Q. And you still are. And in





1968 you became an assistant staff physician at the Hospital, and a year later, 1969, you became staff physician?

A. Correct.

Q. Were both of those appointments, Doctor, in the Division of Cardiology?

A. Yes.

Q. And as well, 1969 as I understand it you became a lecturer in the Department of Pediatrics at the University of Toronto?

A. Yes.

Q. And you have continued in that position until 1972 when you became an assistant professor?

A. Yes.

Q. And since 1976 you have been a senior staff physician in the Division of Cardiology, and that is a position you continue to hold in that division today; is that correct, Doctor?

A. That is correct, yes.

Q. In 1978 you became an associate professor in pediatrics at the University of Toronto, and as I understand it in 1981 you became a full professor, and that is an appointment you continue to hold today as well?







1

2

A. Yes.

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6

Q. Doctor, your counsel has been kind enough to provide to me a copy of your curriculum vitae. I would ask you to look at and identify it for me if you can.

7

THE COMMISSIONER: Exhibit 189.

8

9

MS. CRONK: I'm sorry, sir, what was the exhibit number?

10

11

THE COMMISSIONER: I was waiting for the Doctor to identify it.

12

13

THE WITNESS: Yes, I do.

THE COMMISSIONER: If you do then it is Exhibit 189.

14

15

---EXHIBIT NO. 189: Curriculum Vitae of Dr. Vera Rose.

16

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19

20

MS. CRONK: Q. Doctor, based on my review of your curriculum vitae you hold as well a number of professional memberships, and you are the author of a number of book chapters and publications in the area of cardiology, and they are fully set out in your curriculum vitae; is that correct?

21

A. Yes.

22

23

24

25

Q. Thank you. Doctor, very briefly, can you help me: you have indicated that in 1964 and continuing to today's date you were the







1  
2 cardiologist in charge of what I have described as  
3 the computer system for cardiac records and evalua-  
4 tion for the Division of Cardiology.

5 A. Yes.

6 Q. Can you briefly explain to me,  
7 Doctor, what your responsibilities are in that  
8 capacity?

9 A. I was in charge of the data  
10 system in the Division of Cardiology, and over that  
11 period of time we have been very consistently record-  
12 ing information on patients that we were seeing in  
13 the division. Initially simply on a code system form  
14 and eventually this has been entered into the computer,  
15 and I would be the person who would organize the  
16 system and make sure that all the data that were  
17 entered were sufficiently correct and retrievable,  
18 and this has developed over the years.

19 Q. Doctor, can you help me in  
20 broad terms as to the type of information that is  
21 now computerized for the assistance of the Division  
22 of Cardiology?

23 A. It is basically information  
24 on the clinical data, the history, the clinical data,  
25 the cardiac catheterization, the surgical procedure  
data and the information, the diagnosis at the time





1  
2 of death.

3 Q. Does it also include then,  
4 Doctor, on an ongoing basis information or data with  
5 respect to the number of deaths that occur in the  
6 Division of Cardiology?

7 A. Yes, it is supposed to be  
8 entirely correct, but there is a gap usually of  
9 several months, sometimes a year or two, depending  
10 on how the data gets to us from the Pathology Depart-  
11 ment so it is not entirely precise at any moment of  
time.

12 Q. So there is a delay factor in  
13 terms --

14 A. A delay factor.

15 Q. -- in terms of when the data  
16 is available to be put into the computer system?

17 A. That is correct.

18 Q. And is your responsibility  
19 to oversee the entry of that information into the  
computer base?

20 A. It is not entirely. I  
21 introduce our trainees, our fellows, to the system.  
22 each year and to make them aware of what they have  
23 to do. But I cannot control what everybody is doing  
24 entirely, although we try to do our best.  
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Q. Is the data that is recorded or entered into the computer system, Doctor, broken down in terms of deaths of patients in the Division of Cardiology on a ward by ward basis?

A. Not at all, no.

Q. Not at all?

A. Simply on a diagnostic basis and age basis.

Q. Doctor, we have heard something in evidence about a study conducted by Dr. Fowler and reported in 1975 entitled "Sudden Unexpected Death in Children with Congenital Heart Disease".

That is Exhibit 175, Mr. Commissioner.

Do you recall, Dr. Rose, assisting in that study by reviewing the computer data base and the records at the Hospital for Sick Children to assist Dr. Fowler?

A. I did not assist in that study.

MS. CRONK: All right. Mr. Registrar, could you show Dr. Rose --

THE COMMISSIONER: You did not what?

MS. CRONK: Did not assist.

THE WITNESS: I did not assist in that study.

THE COMMISSIONER: You did not assist?





1  
2 All right. Thank you.

3 MS. CRONK: Q. To help you, Doctor,  
4 the Registrar is showing you a copy of the article,  
5 and perhaps you are in a position to help us with  
6 this, and perhaps you are not. But could I direct  
7 your attention if you would to page 748, the third  
8 page of the article. You see in the last, the very  
9 last paragraph of the article before the reference  
10 section, Doctor --

11 A. Yes.

12 Q. -- there is an acknowledgement  
13 of gratitude to you for helping in reviewing the  
14 computer files. And then a description of the funding  
15 that was available.

16 In fairness to you, Doctor, I  
17 appreciate, as I understand it, it is my information  
18 that you did not assist in the actual preparation of  
19 the article.

20 A. Yes.

21 Q. Can you help me, do you have  
22 any recollection at all in having made available or  
23 being asked to make available the information stored  
24 in the computer data base at the Hospital for the  
25 purposes of the article?

A. This is precisely what I did.







1  
2 Dr. Thornbach was a cardiologist fellow. It was my  
3 responsibility to direct him to the data base in the  
4 division, and it was up to him to review the data  
5 base and get his cases from the data base in the  
6 Division of Records and Evaluation. It is part of  
7 their training.

8 Q. Dr. Fowler has testified with  
9 respect to the purpose of this study, Dr. Rose, and  
10 as to certain other conclusions that are recorded in  
11 the abstract of the article. Are you familiar with  
12 the purposes to which the information contained in  
13 the data base was put and the conclusions reached in  
the article?

14 A. Am I familiar with?

15 Q. With the purposes to which  
16 Drs. Fowler and Thornbach put the information contained  
17 in the data base that Dr. Thornbach retrieved from  
18 their computer records. Are you familiar with the  
19 use to which they put that information and the  
conclusions reached in the article?

20 A. Well, it says here it was  
21 prepared for the Journal commemorating the Centennial  
22 of the Hospital for Sick Children.

23 Q. Well, Doctor, perhaps I can  
24 put the question more succinctly. A question arose  
25





1  
2 during the course of Dr. Fowler's evidence with  
3 respect to the conclusions drawn in the study for  
4 this reason. As appears from the article the gross  
5 study group were some 18,000 patients from the  
6 Hospital for Sick Children ranging in age from birth  
7 to age 21 years.

8 Of those the article indicates 3,055  
9 died before reaching 21 years, and it is also indicated  
10 in the article that some 33 of those 3,055 died  
11 suddenly and unexpectedly between the ages of 1 and  
12 21 years.

13 What the article does not appear to  
14 indicate is how many children of the 18,000 study  
15 group and of the 3,055 deaths died suddenly and  
16 unexpectedly under the age of one year. And I wonder,  
17 Doctor, if you are sufficiently familiar with the  
18 study and the information that was accumulated for  
19 purposes of the study to help us with that: the  
20 number of deaths that occurred under age one year?

21 A. Miss Cronk, the answer is  
22 no.

23 Q. Thank you, Doctor.

24 Dealing then specifically with a  
25 group of children with respect to whose death this  
Commission is concerned, I take it you know that







1  
2 the Commission is concerned with the deaths of some  
3 36 children which took place in the cardiology wards,  
4 Wards 4A and 4B, through the period of July 1980 to  
5 March of 1981? You are aware of that, Doctor?

6 A. Yes.

7 Q. And as I understand it you  
8 were ward chief throughout that nine month period  
9 for approximately three weeks during the month of  
10 July, 1980, and the dates that have been furnished to  
11 me, and I would ask you if you can to confirm their  
12 accuracy, are July 7 to 11, 1980, July 14 to July 18,  
13 1980, and July 21 to July 25, 1980. To the best of  
14 your recollection is that the period of time when  
you served as ward chief?

15 A. I don't recollect entirely,  
16 but if they were furnished to you by Dr. Rowe then  
17 I am sure they are correct.

18 Q. Well, sitting here today,  
19 Doctor, do you have any recollection of having served  
20 as ward chief at the time of the death of Alan  
Perreault, for example, on July 8th, 1980?

21 A. No, I don't think I was at  
22 all responsible at any time for that particular  
23 child.

24 Q. You don't recall being ward  
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chief at the time of his death?

A. I don't know.

Q. All right. Similarly, can you help me with respect to Andrew Bilodeau? He died on July 22nd, 1980. Do you recall being ward chief at the time of his death?

A. Yes.

Q. All right. My information, Doctor, as I have said, furnished to me by your counsel through exhibits that have been marked at the hearing is that those three weeks are the only period during what we have described as the epidemic period during which you served as ward chief and perhaps during the course of your evidence if you are informed of any other period during which you did serve of ward chief you could let me know?

A. I certainly will.

Q. Thank you, Doctor.

MR. TOBIAS: I wonder if we might just have those dates?

THE COMMISSIONER: Well, they don't seem to be absolutely accurate because July 7th to 11th, the 14th to the 18th and 21st to 25th, Perreault died on the 8th of July and Dr. Rose says she was not ward chief at that time. Is that correct?







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THE WITNESS: I don't remember being responsible for the care of this child at any time. And we have reviewed this, I know the chart, but I don't think I was in charge of the ward.

MS. CRONK: That is a matter, Mr. Commissioner, that I will undertake to check with Dr. Rose's counsel. It had been my understanding that technically Dr. Rose had been ward chief during that week.

THE COMMISSIONER: Well, if you are a ward chief, do I not understand that you then automatically, each child that is in the Hospital at the time comes under your care?

THE WITNESS: Yes, that is correct.

THE COMMISSIONER: And you examined the child and if the child died you would certainly be consulted?

THE WITNESS: Yes, that is correct.

THE COMMISSIONER: And you weren't consulted?

THE WITNESS: I don't recall --

THE COMMISSIONER: So it would seem to me that you weren't ward chief.

THE WITNESS: It could have been a weekend and maybe I was not the chief on the weekend.





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2  
3 MS. CRONK: That is possible, Doctor,  
4 and I will look into the matter.

5 THE COMMISSIONER: Yes. All right.

6 MS. CRONK: Q. With respect then  
7 to periods when you are not ward chief, as I under-  
8 stand it there would be periods during the nine months  
9 that we are concerned with when you were on call  
10 either at night or on call on weekends as the staff  
11 cardiologist available for that purpose?

12 A. Yes, that is correct.

13 Q. It is my understanding,  
14 Doctor, that you were on call at night at the time  
15 of the death of Real Gosselin on December 18, 1980.  
16 Is that correct?

17 A. That is correct.

18 Q. Similarly you were on call on  
19 the night that Stephanie Lombardo died? And to help  
20 you, that is December 23, 1980. Is that correct?

21 A. Correct.

22 Q. Again you were on call at  
23 night on the night of Colleen Warner's death which  
24 occurred on March 7th, 1981; is that correct, Doctor?

25 A. Correct.

Q. And finally as I understand  
it you were on call the night that Jordan Hines died





1  
2 which was March the 8th, 1981?

3 A. That is correct.

4 Q. Now, Doctor, as well, I  
5 understand when you were not ward chief and when you  
6 were not on call at night or on weekends there would  
7 be other instances which would lead to your having  
8 some involvement in the care and management of a  
9 particular patient.

10 For example, that would be when you  
11 were ward chief at the time of admission of a  
12 particular patient. Would I be correct in that?

13 A. Yes.

14 Q. Or if the child was referred  
15 to you directly by an outside hospital or a doctor  
16 outside the Hospital for Sick Children you would  
17 necessarily be involved in the care and management  
18 of that child at some stage on its admission to the  
19 Hospital?

20 A. Yes, that is right.

21 Q. Similarly if you were assigned  
22 as the staff physician in respect of a particular  
23 patient would that necessitate your involvement in  
24 the care and management of the patient?

25 A. Only if I were in charge of  
the ward at that time.







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3 Q. All right. So that in those  
4 instances, although you might technically be  
5 designated as staff physician in respect to a  
6 particular patient in the records of the Hospital,  
7 unless you were ward chief you would not necessarily  
8 have any direct involvement in the care and management  
9 of a patient?

10 A. That is correct.

11 Q. May I ask you, Doctor, do  
12 you recall then in any of those capacities, be it as  
13 ward chief at the time of admission, be it referring  
14 physician at the Hospital for Sick Children, do you  
15 recall having had any involvement in the care and  
16 management of David Taylor?

17 A. Yes.

18 Q. And similarly, do you recall  
19 being involved in the care and management of Amber  
20 Dawson?

21 A. Yes.

22 Q. Right. And finally in  
23 respect of the care of management of Michelle  
24 Manojlovich?

25 A. Yes.

Q. Thank you, Doctor. As ward  
chief at the time of death as the Commissioner has





1  
2 alluded to, Dr. Rose, I take it that if you were  
3 ward chief on a particular month when a child was  
4 admitted or when a child died you would necessarily  
5 have direct involvement in the care and management of  
6 that patient?

7 A. Yes.

8 Q. Right. And if you were not the  
9 ward chief but you were the staff cardiologist on  
10 call, be it at night or on weekends, you would be  
11 the cardiologist called by the attending physician  
at the time of arrest of this child?

12 A. That is correct.

13 Q. And when you were called by  
14 the attending physician, as I understand it, you  
15 might in some circumstances come into the  
16 Hospital before the child was actually pronounced  
17 dead, or, alternatively, you might simply be informed  
18 via telephone by the attending physician as to the  
19 child's clinical circumstances and the terminal events  
that he or she was then exhibiting? Is that correct?

20 A. That is correct.

21 Q. And if you did come in before  
22 the child was pronounced dead, as the staff cardiolo-  
23 gist on call I take it you would then be involved in  
24 whatever resuscitation efforts might be underway, if  
25





1  
2 any, and you would personally examine the child?

3 A. I would be consulted by the  
4 resuscitation team as to what more to do or what  
5 suggestions I might have.

6 Q. All right. And you would be  
7 physically in the room and examine the child or at  
8 least observe the child at that time?

9 A. Observe the child, yes. There  
10 would be too many people around the child for me to  
11 get close.

12 Q. And in those circumstances,  
13 Doctor, where you were staff cardiologist on call,  
14 whether or not you came into the Hospital while the  
15 arrest procedures were underway, do I have it  
16 correctly that when you did arrive at the Hospital,  
17 be it at the time of the resuscitation efforts or  
18 later in the day, you would have occasion to review  
19 the medical record of the child?

20 A. Yes.

21 Q. And as a matter of practice,  
22 would you do so when you were staff cardiologist on  
23 call and a child had died on the wards?

24 A. I would always do so.

25 Q. Always do so? If you were  
ward chief at the time of the admission of the child







1  
2 as opposed to being on call at the time of death, I  
3 take it it would be one of your responsibilities to  
4 examine the child at the time of admission?

5 A. Yes.

6 Q. Would you necessarily there-  
7 after, Doctor, follow the care and progress of this  
8 child on the ward?

9 A. Not in an official capacity,  
10 but very much in consultation with the ward chief.

11 Q. So you would be aware of the  
12 child's course on the ward?

13 A. Usually, yes.

14 Q. And finally as staff physician  
15 or referring physician, if that were the case, I take  
16 it you would have direct involvement in the care and  
17 management of the child?

18 A. Yes.

19 Q. Thank you. Doctor, we have  
20 heard in evidence from Dr. Fowler that the cases of  
21 the 36 children with which this Commission is  
22 concerned were reviewed amongst the members of the  
23 Cardiology Division at the Hospital in preparation  
24 for these hearings.

25 Dr. Fowler's evidence in this regard,  
Mr. Commissioner, is in Volume 34, page 6739, 6743.





1  
2  
3 To help you, Dr. Rose, Dr. Fowler  
4 testified that each member of the Cardiology Division  
5 senior cardiologists, reviewed the charts and records  
6 that he or she was most familiar with, having been  
7 involved in the care of the patient, and then met  
8 with the other members of the group for the purposes  
9 of reviewing every patient of the 36 at a series of  
10 several meetings.

11 Can you help me, first, Doctor, did  
12 you participate in that joint review of the medical  
13 records of these 36 children?

14 A. I think I should make a  
15 correction here. We did not have several meetings.  
16 We prepared the summaries on the advice of counsel.

17 Q. Yes.

18 A. For his purposes, for his  
19 review, and for Dr. Rowe who had to go over all 36  
20 patients.  
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Q. Did you, after the preparation of summaries by the various members of the division, did you then meet as a group to review the information contained in the summaries of these children?

A. Not to review but to add information that might be available to the other cardiologists who were involved with the case. Simply to add information, not to review, but to add.

Q. All right. Doctor, I will return to the question of that review process and the preparation of the summaries in due course. For present purposes, can you help me sitting here today, do you recall which medical records you were asked to review in detail, and in respect of which records you prepared summaries for the use of the cardiology group?

A. I don't remember precisely but it would have been the summary of patients I was directly involved with as Ward Chief.

Q. So in that instance then we know that a minimum, because you have indicated you were ward chief at the time of the Andrew Bilodeau's death and it would have included his file?

A. I think Andrew Bilodeau was mine.

Q. And you don't recall any others at the present time?







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A. I think I prepared the report of the chart of Hines because I was on that night, but I don't recall any others.

Q. Doctor, I propose very briefly to refer you to the evidence of Dr. Rowe with respect to the children that you had some direct involvement with, and for the most part I don't believe it will be necessary for you to refer directly to the medical record of the child, but if you wish to do so and I have not otherwise made it available to you, please don't hesitate to ask.

With respect then to the first child when you have indicated you were ward chief, that of Andrew Bilodeau. Mr. Registrar, it may be of assistance to Dr. Rose to have this record, it is Exhibit 42.

Do you have that record, Doctor?

A. Yes.

Q. Could I ask you briefly, Doctor, to turn to page 20 if you would, which is the Death Report prepared following the death of Andrew Bilodeau. I see some initials on the bottom left-hand side of the page, as I understand it those are yours, is that correct?

A. Yes, this is the final summary report, not the death report.





B.3

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Q. All right.

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A. They called it the death report,  
but it is the case summary.

5

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Q. I refer to it for that reason  
only, Doctor, because it is a description at the top  
of the page.

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11

If I can refer you to the last paragraph  
in the death report and the last sentence in the  
paragraph, the course of the child and his management  
over the weekend after his admission to the Hospital  
are referred to and in the report concludes:

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"Despite these measures, the baby  
gradually deteriorated until he  
sustained a cardiorespiratory arrest  
at 1:30 a.m. on the 22nd of July,  
which after vigorous attempts at  
resuscitation for half an hour, he  
failed to recover. Permission has  
been asked for an autopsy."

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Do you agree, Doctor, based on your  
knowledge of the clinical condition and terminal  
events of this child that that paragraph and that  
sentence to which I have drawn your attention is a  
fair description of his course over the period of his  
last admission to the Hospital, that he was in a  
state of gradual deterioration?





B.4

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A. Yes.

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Q. Doctor, could I refer you then

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as well to page 5 of the record if you would, which is

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a reporting matter as I understand it, to the

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referring family physician, Dr. Patel. Can you help

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me, Doctor, is that your signature on the reporting  
letter?

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A. Yes, it is.

9

Q. Can you help me, Doctor were

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you the referring physician as well as the ward chief

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in respect of this child?

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A. I was the Ward Chief. The child

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was admitted on the weekend to whoever was on call

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on the weekend, it happened to be Dr. Fowler.

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THE COMMISSIONER: I am having trouble

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again with this term "referring physician". Is there

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I can understand you referring a patient to a surgeon,

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but I would have thought that somebody referred the  
patient to you, maybe I am wrong?

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THE WITNESS: What happens, if a

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child is admitted, sir, on the weekend, it's the

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referring physician on the outside.

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THE COMMISSIONER: Yes.

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THE WITNESS: The general practitioner

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asks who the cardiologist on call is and he will

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B.5

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then refer the child to the cardiologist on call, so

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Dr. Fowler ---

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THE COMMISSIONER: It is described as

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the "referring" - if you look at page 20, referring

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physician, that is The Hospital for Sick Children.

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THE WITNESS: Yes.

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THE COMMISSIONER: That is Dr. Fowler?

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THE WITNESS: That is right, because

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he was the cardiologist on call when the child was

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referred to the Hospital. Okay, he was the one the

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child was referred to, I took over as the Ward Chief.

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THE COMMISSIONER: I would have thought

it should be referred rather than referring.

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THE WITNESS: Absolutely, yes.

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THE COMMISSIONER: As long as we know

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what the term means. The referring physician refers

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to the cardiologist who is, first took up the cause?

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THE WITNESS: Yes, who received the

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child and had the first contact. In other words, this

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child, once he is discharged would then be followed

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by the referring cardiologist. So this child if he

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had survived would have been followed by Dr. Fowler,

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not by me.

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THE COMMISSIONER: Back on page 20, how

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do you become staff physician?





B.6

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THE WITNESS: I was the staff physician because I was the staff physician attending on the ward. I was in charge of the patient. The referring HFC cardiologist is Dr. Fowler and he would have followed him after discharge from the Hospital.

THE COMMISSIONER: But you would have followed the child during the period?

THE WITNESS: During the period when he was in Hospital as the staff cardiologist on the ward.

THE COMMISSIONER: Would you continue to do that after, at that time I take it you were in fact the ward chief?

THE WITNESS: That is right.

THE COMMISSIONER: Would you have been, if you had not been the ward chief would you ---

THE WITNESS: I would have had no involvement with this child.

THE COMMISSIONER: Supposing the child stays there for six months, I don't know whether that very often happens?

THE WITNESS: I would have then passed the child on to the ward chief who followed me. There might be in the course of a child's long hospitalization several staff cardiologists in charge of the patient,





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but Dr. Fowler would always remain.

THE COMMISSIONER: Always remain as  
the referring physician?

THE WITNESS: Yes. The reason we have  
referring, because some of our patients are referred  
from the clinic or from a private practice of the  
cardiologist, and they would be the referring  
cardiologist.

THE COMMISSIONER: Would it not ever  
happen that you might become so involved in the treat-  
ment of this child that you would carry on with the  
treatment of the child, notwithstanding the fact  
that Dr. Fowler was originally ---

THE WITNESS: No, I think this wouldn't  
happen, or shouldn't happen, it is not considered  
ethical procedure, you would pass the child back to  
the referring cardiologist, it is his patient.

THE COMMISSIONER: Yes, I see. All  
right, thank you.

MS. CRONK: Q. Do I correctly understand  
then, Dr. Rose, that if you were the ward chief, the  
staff physician who was assigned to the ward at the  
time of the child's death, you would then be described,  
as you have been in this case, as the staff physician  
on the death report and the final summary report?







B.8

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A. Yes.

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A. Yes, that is right.

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Q. And had the child been in the Hospital for a lengthy period of time with a number of staff physicians caring for him, it would be that staff physician that was ward chief at the time of death who would be designated as staff physician on the death report?

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A. It does sometimes happen that if we have more involvement, or we thought we had more involvement and we discussed it amongst ourselves and one of us would write the letter. I wrote this letter because I felt unhappy about this child, the fact that we couldn't keep him going.

Q. Doctor, bearing that in mind and





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bearing in mind as well the description of the patient's course in the Hospital that we have seen from the death report, can you help me as to what you meant in the first paragraph of your referring letter when you indicated that first you were enclosing a copy of the final summary report on the patient; and secondly that the child had died rather suddenly and unexpectedly on the night of the 22nd of July, 1980?

A. Yes. This child had the diagnosis of truncus arteriosus. If you recall Dr. Rowe showed you the diagram. Truncus arteriosus is a very serious problem and unfortunately we have not had much success in the surgery we have done for this condition and the risk of death is very high.

However, I am always hopeful when I see a child like that, because even though the risk is 90 per cent, there is always a 10 per cent chance the child will live. So that I felt that if we persisted in treating this child very vigorously with heart failure that this child would survive. I was also disturbed, as you see in the second paragraph, that when the diagnosis was made by echocardiogram in the afternoon of the - I am not sure which date it was, but the day before the child died. The parents had left the Hospital and I was unable to explain to





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them the serious nature of the child's problem and the course of possible therapy that we could undertake. This disturbed me because I felt they should know how sick the child was. They had no telephone and I had no way of contacting them. I was hoping very much that we could make the child live through the night so we could do catheterization and discuss it with the surgeons and consider surgery even though that was a very high risk. So what I am expressing here "suddenly and unexpectedly" is my own disappointment and frustration that this child died.

Q. When you, as I understand it, Doctor, you have said in part that part of your distress was because you had been unable to explain to the parents after I take it the echocardiogram?

A. Right.

Q. The gravity of the child's anatomical condition and what you expected the likely treatment would be, or what it would entail?

A. Yes.

Q. Can you help me, Doctor, when you left the ward that evening, the evening prior to the child's death, did you have any anticipation that the child was in imminent danger that evening?

A. I have been told that his cardiac







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failure had worsened. I had been told by the doctor who was doing the echocardiogram that the child was quite sick and sweaty and not doing well. I knew what medications the child was on for the treatment of his heart failure and they were appropriate. That is the state in which I left the case. I talked to the doctors who were taking over from me.

Q. That status report and the description of those symptoms to you, were they consistent in your view with the gradual deterioration in the child's condition?

A. I think so, yes.

Q. Dr. Rowe in his evidence before this Commission, Dr. Rowe expressed the view and this opinion is found at Volume 11, Mr. Commissioner, at page 1806, that nothing The Hospital for Sick Children could have done for this baby could have saved him. Is that an observation with which you agree?

A. Nothing could have been done? That is probably correct. As I told you, I am always hopeful that something can be done, and we have in certain cases attempted surgery and treatment and have been successful, so I never give up hope.

Q. Doctor, as well there has been





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some suggestion given in a note contained in the progress notes of this record, there was some indication that consideration of transferring the child to the Intensive Care Unit was undertaken. As Ward Chief do you recall any discussion to transfer this child to the Intensive Care Unit prior to his death?

A. I don't recall any discussion as I was not on call the night the child died. I believe it was Dr. Olley who was on call. It was often discussed and if space is available in the Intensive Care we will often transfer the child to Intensive Care.

Q. Prior to the actual night of his death, Doctor, in respect of this particular child, do you have any specific recollection of a discussion with respect to him as to whether or not he should be transferred to the Intensive Care Unit?

A. No.

Q. And I take it then, because you don't recall the discussion of that kind, you would similarly not have any recollection as to whether the decision was made that the child should be transferred to the ICU but was unable to be transferred for reasons particular to the complement of the ICU at that time, you can't help us with that?





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A. No.

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Q. Doctor, as well Dr. Rowe

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testified before the Commission, that in his view the

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death of this child was adequately explained by the

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child's cardiac condition; and that although the

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onset of his terminal events was sudden it was not

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to Dr. Rowe surprising. Do you share those views?

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A. Yes.

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Q. Doctor, do you have anything to

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add with respect to the death of this child other

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than the evidence of Dr. Rowe to which I have just  
referred you?

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A. No.

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Q. The next child with which you

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as I understand it had some involvement, Doctor, was

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David Taylor, who was admitted to the Hospital on

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July 25th, 1980, and who died two days later on July  
27th, 1980.

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As I understand it you were again

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described as the staff physician at The Hospital for

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Sick Children on the death report with respect to this

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child. Do you remember having involvement in his care  
while he was in the Hospital?

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A. Yes.

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Q. Dr. Rowe testified with respect

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B.14

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to this child, Doctor, and this evidence, Mr.

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Commissioner, is found in Volume 11, page 1842 to

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page 1843, that a diagnosis of suspected endocardial

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fibroelastosis had been made during the child's life.

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Do you recall that diagnosis having been suspected,

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the diagnosis having been made?

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A. It was one of the diagnoses but it wasn't the primary diagnosis of this child. This child did not have primary endocardial fibroelastosis. He had aortic stenosis, severe aortic stenosis. Children with severe aortic stenosis, as you will recall from Dr. Rowe's diagrams, will often have sclerosis or endocardial fibroelastosis in association with the severe aortic stenosis which worsens the prognosis.

Q. Well fairly, Doctor, Dr. Rowe also testified, as you have just indicated, that the predominant or major problem during life for this child was thought to be severe aortic valve stenosis.

A. Right.

Q. He did however testify as well that it was suspected at this time that the child had endocardial fibroelastosis as well.

A. Correct.

Q. And I take it that you agree with that?

A. Yes.

Q. Right. Doctor, as I understand it, there are, as it happens, two forms of endocardial fibroelastosis, is that correct?

A. Yes.





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Q. Could you briefly describe for us what the two forms are and which David Taylor had?

A. The two forms are the contracted type, which is the type that is associated with conditions such as David Taylor's, namely, aortic stenosis, sometimes mitral stenosis and some hypoplasia of the left side of the heart.

The other type is the dilated type. It is usually not associated with any structural malformation of the heart. The heart is a small, what we call a cardiomyopathy, muscle disease of the heart. The heart is very large and dilated and the lining of the left chamber is sclerosed and thickened with endocardial fibroelastosis.

Q Do either of the two forms, Doctor, in your view and experience carry with it a particular susceptibility to digoxin intoxication, or do they both?

A. We would be more cautious in a child with cardiomyopathy and endocardial fibroelastosis with the dosages of digoxin that we administer.

Q. And that I take it --

A. Because they are more sensitive.

Q. I'm sorry, Doctor, they are more sensitive to digoxin toxicity?







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A. Yes.

Q. And that I take it from your description would be the form of endocardial fibroelastosis you have described as dilated?

A. Yes.

Q. All right. And that is not what David Taylor as it happens had?

A. No.

Q. He had the contracted version?

A. Yes.

Q. Right. I take it then that there was not a particular concern in David Taylor's case with respect to the medication regime, the dosages of digoxin that were to be prescribed to him based on the suspected diagnosis of endocardial fibroelastosis?

A. I think there is in critical aortic stenosis as well, we are cautious with the digoxin dosage because digoxin affects - the digoxin increases the contractility of the heart and the valve is very narrow, the contractility is increased and this may have a strain effect as well.

Q. As part of the general caution that would be exercised because of that suspected diagnosis, would the dosages of digoxin to be prescribed





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be reduced?

A. Not necessarily but they would be closely watched.

Q. All right. And did that happen with respect to David Taylor?

A. I think any child that is pre-scribed digoxin is very carefully assessed, his weight and the dose prescribed is according to the child's weight and the response is followed very carefully. We have a responsibility to our fellows and residents to teach them to assess the patient, to carefully calculate the dose when they administer it, to follow the dose and to follow the response of the child to this administration of digoxin and diuretics in respect to the child's clinical condition, the electrocardiogram, chest x-ray. That's the first line.

Q. Thank you. Doctor, so that I understand it. Given the general caution that would prevail because of the suspected diagnosis in this case, do you have any recollection that the amount of digoxin doses prescribed for the child were reduced as a result of a concern, for example, that he might have dilated endocardial fibroelastosis as opposed to the contracted variety.

A. I don't think they were reduced





Rose, dr. ex.  
(Cronk)

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as I recall it.

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Q. Thank you. That is my understanding, Doctor, but I wanted to be sure that that was yours as well.

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A. Yes.

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Q. All right. Dr. Rowe testified with respect to this child, Doctor, that the autopsy that was performed after the child's death demonstrated in fact a more severe condition than had been suspected during the life of the child and that once he received the final autopsy report he felt the child's death had been adequately explained given the child's anatomical condition as revealed on the autopsy. Is that a conclusion, an opinion with which you would agree?

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A. I would agree with that.

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Q. Thank you. Do you recall, Doctor, any discussion following the death of David Taylor, be it at the morning cardiology conference which followed on the day of his death or subsequently any discussion amongst the cardiologists who had been involved in his care, as to whether or not digoxin intoxication had played any part in the death of the child?

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A. We did not discuss digoxin







(Cronk)

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intoxication but we discussed the case.

Q. All right. But you don't recall any specific, any suggestion being raised by any member of the cardiology division as to whether or not digoxin intoxication might have played some part or contributed to his death?

A. There was no such point raised about that.

Q. Thank you. Doctor, as I understand it, the next child with whom you had some direct involvement was that of Amber Dawson who was admitted to the hospital on the 23rd of July, 1980 and who died on July 28th, 1980. You were, as I understand it, again ward chief at the time of her admission rather than at the time of her death, is that correct?

A. Yes.

Q. Right. Dr. Rowe testified with respect to this child and this child's death, Dr. Rose, that she had experienced a sudden onset and rapid course of terminal events; that evidence is found at Volume 12, page 2128 to page 2129. Are you sufficiently familiar with her course in the hospital, Doctor, and the terminal events that were sustained by her to offer us an opinion as to the progress of those





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terminal events?

A. I don't think with regard to the terminal events I am sufficiently familiar but I knew the child very well. She was very sick, very debilitated.

Q. And as you were ward chief at the time of her admission I take it you saw her then?

A. Yes, I saw her at the time of admission and I discussed the plan of procedure, what was to happen to her, what we were going to do with her with the surgeons.

Q. And thereafter did you follow her course on the ward?

A. Yes. I think she was only in for a day or two as I recall before she died. She had been readmitted. I had known her before. In fact, I had arranged her transfer back to Sudbury at her mother's request.

Q. Yes, there were a series of hospitalizations for Amber Dawson, Doctor.

A. That's right.

Q. But dealing simply with the last admission after you saw the child and she went back to the ward you have told me that you discussed the treatment that was to be made available for her.





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A. That's right.

Q. And while she was on the ward during the period of her last admission did you follow her progress and the state of her condition?

A. Yes, I followed her, yes, during the day time.

Q. Yes.

A. I knew about her progress, I knew about her nutritional problems, I knew about her paralysed diaphragm and discussing it with Dr. Trusler about the possibility of plicating the diaphragm.

Q. Yes.

A. That she had problems with aspiration as a result of this diaphragm problem. There was evidence of sepsis I think in the terminal stages, the day before she died I believe. Those things I recall. If you give me the chart I might recall some more.

Q. If you would like the chart, Doctor, it is available.

A. That depends on your question.

Q. Well, let's try one more, Doctor, and if you want the chart please feel free to ask. Dr. Rowe testified that at the time this child died prior to the autopsy that he was not personally





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3 absolutely sure as to why the child had died and in  
4 the way and at the time that she did. That evidence,  
5 Mr. Commissioner, is found at Volume 12, page 2129 to  
6 page 2130. After the child died, Doctor, did you  
7 formulate an opinion as to the likely cause of death?

8 A. Yes. I think it has to be stated  
9 that this child had multiple problems. I think this  
10 is a very typical case of multiple causes contributing  
11 to the death of a very debilitated child. This child,  
12 I cannot enumerate them, I have got them written down  
13 somewhere, if you would like I would just tell you  
14 this because I did write them down.

15 Q. Could you perhaps Doctor tell us  
16 what, if you are in a position to do so, what your  
17 opinion was when the child died and what you considered  
18 significant in formulating that opinion? As we  
19 understand it, Dr. Rowe reached an opinion following  
20 the autopsy results, but at the time of her death he  
21 was in some uncertainty as to why she had died.

22 A. I think it is sometimes difficult  
23 when a child has multiple problems just what the  
24 precise mode of death is in this child. She was  
25 hypoxic, she had sepsis, she had respiratory problems  
as a result of her paralysed diaphragm. Her temperature  
was unstable, she was a low birth weight child. I







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don't think there was anything else specifically but  
her poor nutritional state ---

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THE COMMISSIONER: Excuse me, I have  
the fact that she was hypoxic, and I missed the second  
one.

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MS. CRONK: Sepsis.

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THE WITNESS: Sepsis.

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THE COMMISSIONER: Sepsis, yes.

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THE WITNESS: That's right.

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THE COMMISSIONER: And that she had... ?

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THE WITNESS: She had respiratory  
problems.

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THE COMMISSIONER: Respiratory problems?

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THE WITNESS: Because of her lung being  
reduced in volume as a result of her paralysis. She  
couldn't move her diaphragm on one side and this gave  
her severe respiratory problems.

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THE COMMISSIONER: And her temperature  
was... ?

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THE WITNESS: Unstable. This was noted  
by the nurses on the chart. She was initially a low  
birth weight child. She had had two operations. She  
had had a pulmonary artery banding initially and she  
had repair of ventricular septal defects. It was as a  
result of the second operation that she developed the

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paralysis of the right hemidiaphragm.

Now, I think in a case like this we were very concerned, and also she was in a very poor nutritional state. So, just what tipped the balance is sometimes very difficult to ascertain.

Q. All right, Doctor, following her death and prior to the conduct of the autopsy did you have any question in your own mind as to what had triggered that event, the event of her death?

A. No, I had no particular question, no particular thing I could focus on except that this was a very sick child who died.

Q. Were you satisfied at that stage Doctor prior to the autopsy that the death was consistent with the child's clinical and anatomical condition?

A. I think so, yes.

Q. All right. Dr. Rowe, to help you Dr. Rose, testified that following the autopsy there was evidence revealed or disclosed of perforation at the upper end of this child's stomach and that once that had been disclosed by the autopsy he testified that he thought it was a possibility that the stomach perforations of and in themselves had triggered her cardiac arrest.





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A. Yes.

Q. Is that a view you share?

A. Yes. This might have just tipped the balance. But it was also found at autopsy that her heart muscle was very sclerosed and had some fibrosis in it. In other words, she did not have a very good normal myocardium and this might have weakened her a sufficient degree that she might have arrested as well. So, I think it is not a single cause of death you can put your finger on. The perforation might have tipped the balance.

Q. Well, Doctor, perhaps I can phrase the question this way. Dr. Rowe testified in addition to his comments with respect to the perforations found at the upper end of the stomach that it was possible that the child's respiratory problems, to which you have alluded, could have explained her death. He did however indicate that there was still some doubt about the direct cause of her death.

A. Yes.

Q. I take it that insofar as he was directing his attention to what precisely had triggered the arrest and caused her death you would share that view?

A. Yes I would.







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Q. All right. Doctor, do you recall any other matter during the course of that child's last evening in the hospital which you considered to be of significance in contributing to her death other than those factors which you just outlined?

A. Well, I outlined one of them and that was sepsis and I think this was suspected I believe the evening before. Again, I couldn't give you details but I believe there was a reason to suspect that she had some infection.

Q. All right. Well, Doctor, Dr. Rowe testified as well with respect to the terminal events and the course of the terminal events following their onset that in his view those events and their course were consistent as well with digoxin intoxication. Are you sufficiently familiar with the terminal events of this child to agree or disagree with Dr. Rowe's evidence in that regard?

A. I'm not sufficiently familiar with the terminal events but I don't think - they might be consistent but they are not indicative of digoxin intoxication.

Q. All right. I take it then to the extent that you are familiar with those events and the child's condition you would agree that they are





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consistent with digoxin intoxication?

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A. Yes.

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Q. Thank you. Doctor, do you recall

5

attending a meeting with Sergeant Shirlow and

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Constable Murray of the Metropolitan Toronto Police

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Force on July 28th, 1982 at which the death of Amber

8

Dawson was discussed. Do you recall attending that

9

meeting?

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A. Yes, I was trying to remember

the date, thank you very much for giving it to me.

11

Q. My information is that it was

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July 28th, 1982.

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A. Yes.

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Q. Do you recall attending that

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meeting?

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A. I recall it, yes.

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THE COMMISSIONER: Sergeant Shirlow

and who else?

18

MS. CRONK: Sergeant Shirlow, sir, and

19

Constable Murray of the Metropolitan Toronto Police

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Force.

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Q. And do you recall Doctor the

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death of Amber Dawson being discussed at that meeting?

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A. Yes.

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Q. All right. Do you recall

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expressing the view during the course of that interview, Doctor, that when Amber Dawson had died on July 28th, as it happens, the same day but two years earlier, 1980, it was felt that she had aspirated and that that was quite possible, given her condition, because she was very weak?

A. Yes.

Q. Do you recall expressing that view?

A. I must have said it if it states it.

Q. Do you recall as well, Doctor, expressing the view that in your opinion had there been enough nurses on duty that night this might not have happened?

A. I'm sure I didn't say that. I don't think that interview was recorded on tape. I think they asked me about my awareness of the nurses on the ward and I expressed some concern that I was aware that maybe there were not as many nurses on at night as during the day, but since then I think I have been told there are the same number of nurses on the ward.

Q. Well, Doctor, perhaps we can deal with it in two stages then. Sitting here today





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I take it that you do not recall having made that  
remark to the officers that interviewed you on July  
28th, 1982?

A. Right.

Q. Right. Can you help me Doctor  
as best you can to the best of your recollection as  
of the end of July, 1980, the end of the first month  
of the summer of 1980, did you at that time have any  
perception or impression that the cardiology wards  
were suffering from a shortage of nursing staff at  
night?

A. That's a long question, would  
you just tell me precisely what you mean?

Q. All right, Doctor, I will try  
again. At the end of July, 1980, the time that Amber  
Dawson died, she died on the 28th, the end of the  
month, 1980. To the best of your recollection today  
did you at that time have any perception or impression  
that the cardiology wards were suffering from a  
shortage of nurses at night?

A. Yes, I think that's correct.

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Q. Now, Doctor, that, as I have indicated, is the end of July, 1980.

Can you help me as best you can recall as to the basis upon which you formed that impression?

A. Simply that when I came into Hospital at night I did not see as many nurses as I did during the daytime. I now realize it was the absence of the head nurses, the absence of the student nurses, the absence of the clinical teachers at night and so on which gives you the impression that there are fewer nurses.

Also the fact that during the day the mothers are available to feed the children, take care of them, and at night the nurses have to do that job, so they were not as visible in the nursing station possibly.

It was my impression there was a shortage, and my concern that if there are a number of very sick babies that we obviously require more nursing help on the ward, and that was a real concern.

Q. And that was a concern that you had at the end of July, 1980?

A. Right.

Q. Did you have any particular concerns, Doctor, with respect to the death of





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Amber Dawson that an insufficient amount of nursing care or medical care might have contributed to that child's death?

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A. No, I didn't. No, I think this was part of my concern about nursing coverage at night when there were sick babies, the fact that I didn't see many nurses, the same when I came in for other patients.

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Q. Doctor, I take it then that your impression as to the shortage of nurses flowed from the fact that when you visited the ward at night you saw fewer bodies?

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A. Yes, definitely.

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Q. There seemed to be less people on the ward; is that correct?

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A. Yes.

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Q. Would I be correct in taking from that, Doctor, that you did not have the impression at that time that there had been more nurses available for night duty in the months prior to July? For example, in March, April or May of 1980?

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A. No. That is incorrect. I didn't form that impression.

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Q. All right. It was just a question of what you perceived to be fewer people around at





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night when you entered the ward when you were  
on duty?

A. Yes.

Q. All right, thank you, Doctor.

Doctor, are you familiar with the  
concepts of what has been described to this Commission  
as constant care and shared care nursing duties?

A. I am not familiar with that.

Q. Doctor, can you help me, with  
respect to the nine month period that we are discussing  
and the children in whose care you were involved, did  
you ever have occasion during that nine month period  
of time to request that more than - that a particular  
child have the care of one nurse or two nurses only  
devoted to that child?

A. Not during that period of time.

Q. All right. If, Doctor, in your  
view a child on the cardiology wards as distinct from  
a child who was transferred to the ICU or was  
transferred to the neonatal wards, required closer  
monitoring or closer observation due to the gravity  
of the child's condition, what in those circumstances  
would you as the attending physician do to ensure  
that closer monitoring was available for the child on  
the wards?







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A. We could only ask for additional nursing care. That didn't mean that we would actually get it.

Q. All right. Do you recall, Doctor, again in this period with respect to the children in whose care you participated, asking for additional care and it not being provided for any reason, whether it was unavailable or because it couldn't be done on a particular day or night on which you had requested it?

A. All I can say is that we discussed it amongst ourselves when we had our meetings in September, and we considered that we had a requirement here because of the number of sick babies that we had for more nurses, for more constant nursing care or intermediate intensive care, and this is how we formulated our idea of having an intermediate intensive care to help the nurses when they had a number of sick babies on the ward.

Q. Well, apart from the discussions, Doctor, and I will return to that in just a moment, which took place at what we have had described to us as the mortality and morbidity meetings in September of 1980, do you personally in respect of any child under your care recall asking for an increased level





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of nursing care only to find that it could not be  
provided for a particular time?

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A. No, during that particular time,  
no.

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Q. Thank you, Doctor.

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You have mentioned as well obviously  
the meetings that we have heard were held on September  
5th and September 26th, 1980.

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A. Yes.

10

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Q. The mortality and morbidity  
meetings.

12

A. Yes.

13

Q. Doctor, can you help me, were  
you in attendance at the meeting of September 5th, 1980?

14

A. Yes.

15

16

Q. And were you as well in attendance  
at the meeting of September 26th, 1980?

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A. I don't think so. I am not sure.

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Q. Can we deal first with the  
September 5th meeting and we will come back to the  
September 26th meeting.

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Dealing with the first meeting, Doctor,  
you may recall that the deaths of the Bilodeau child,  
the Turner child and the Taylor child were discussed  
at that meeting. Two of those children were patients

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with respect to which you had some involvement?

A. Yes.

Q. Do you recall, Doctor, a discussion at the meeting of September 5th by any of those persons who were present with respect to the possibility that digoxin intoxication had contributed in any way to the deaths of those three children?

A. No, I don't recall any discussion of digoxin.

Q. All right. Apart from the formal meeting itself and the discussions that day, do you recall anyone, be it a member of the medical staff or a member of the nursing staff, raising with you the issue of digoxin intoxication as a possible contributing factor to those deaths, either prior to the September 5th meeting or after the meeting itself had actually been held.

Do you recall that being raised?

A. No.

Q. Right. Doctor, with respect to the September 26th meeting, to help you fairly it is my understanding that you may very well have been present at that meeting, and perhaps if I could ask, Mr. Registrar, could you show Dr. Rose Exhibit 52 if you would, please?





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Exhibit 52, Doctor, to assist you, are notes which we understand were taken by one of the nurses present at the September 26th meeting.

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A. Yes.

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Q. Although the author of the notes has not been identified formally in evidence yet.

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If I could ask you to look at the notes, Doctor, there seems to be an indication that you were in attendance at the meeting.

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Does that help you to refresh your memory?

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A. September 11th? Is that what you are talking about? This is September 11th.

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Q. If you look below that, Doctor, you will see the date September 26th under the heading "mortality rounds" on the first page?

15

16

A. Oh, yes.

17

Q. Do you see that, Doctor?

18

A. Yes.

19

Q. And if you look to the list at the bottom of the page there appears to be an indication of the persons who were present at the September 26th meeting.

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21

22

A. Yes.

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Q. There is an indication of

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Dr. Jedeikin, Dr. Schaffer, Dr. Rowe, Dr. Rose,

3

Dr. Olley, Dr. Izukawa and Dr. Duncan.

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5

Fairly, Doctor, these may not assist  
you at all, but looking at them now do you have any  
recollection of having attended the September 26th  
meeting?

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A. I still have no recollection,  
but if my name is there I must have been there.

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Q. After the September 5th meeting  
then, Doctor, quite apart from any recollection  
specific to the September 26th meeting, do you recall  
during the month of September or thereafter any  
discussion by any member of the Cardiology Division  
or anyone raising with you the possibility that  
digoxin intoxication might have contributed to the  
deaths of the children that had been reviewed at those  
mortality meetings?

17

A. No.

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Q. Thank you very much, Doctor.

Doctor, as I understand it, the next  
child with whom you had some direct involvement was  
Real Gosselin?

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A. Yes.

MS. CRONK: And, Mr. Registrar, could  
I ask you to provide Dr. Rose with the record in this  
case? It is Exhibit 72.





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Q Doctor, this child was admitted on December 17th, 1980 and died several hours later in the early hours of December 18th.

As I understand it you were on call the night of his death?

A. That is correct.

Q As I understand it as well, Doctor, you were called at the time of the child's arrest, and you actually came to the Hospital after the resuscitation efforts had been commenced but before the child had been pronounced dead. Is that correct?

A. I think the child had been pronounced as I recall. They were 45 minutes into the arrest.

Q By the time you arrived?

A. I am pretty sure. I think I arrived at the end to tell the parents that their child had died.

Q Do you recall speaking to the parents after the child had died?

A. I recall speaking to the parents, yes.

Q Did you at that time express any opinion to the parents as to the child's cause of death?





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A. Well, I had reviewed the chart and I must have - I don't recall precisely what I said but I must have explained the cardiac problem and my view of the reasons as to why this child died.

Q. Right.

A. And asked them for an autopsy consent.

Q. I take it then, Doctor, that although you arrived after the child had been pronounced dead and the resuscitation efforts had terminated, you then had an opportunity to review, first, the medical record of the child?

A. Right.

Q. Is that correct? And secondly, I take it you would have been informed by the attending physician or attending resident as to the nature of the terminal events sustained by the child and the method, the course of those events progressing to her death?

A. Right.

Q. Do you recall, Dr. Rose, discussing the death of Real Gosselin at any time with Dr. Freedom before Dr. Freedom wrote a reporting letter to the referring physician in Manitoba who had sent the child to The Hospital for Sick Children?







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A. I am not sure if I discussed it before or after he wrote the letter, but we certainly talked about this child and the reasons as to why this child died including the response to the medication the child had.

Q. To help you, Doctor, the reporting letter written by Dr. Freedom is dated December 18th, 1980. It appears at page 35 of the medical record. That is the same day that the child died.

Do you recall at the morning staff cardiology conference following the death of Real Gosselin having discussed this case specifically with Dr. Freedom?

A. I really cannot recall at this time two and a half years after what precisely we said at the morning meeting, but I discussed the case many times with Dr. Freedom, and discussions evolved about the fact that was the prostaglandin effect a good effect or was it not, and that the child died because of the severe coarctation or did it die because of the prostaglandin, and we agreed on reviewing the child's clinical record and the child's progress that the death was caused by the child's severe defect and heart failure as a result of it and an inadequate response to prostaglandin.





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MR. STRATHY: I am sorry, I am having  
a little bit of trouble hearing. Towards the end of  
the sentence.

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THE WITNESS: What would you like me  
to repeat?

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MR. STRATHY: Just the last bit of it,  
please?

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THE WITNESS: We thought the child  
died of severe heart failure as a result of an  
inadequate response to prostaglandin in keeping the  
ductus open, keeping the flow to the kidney going.

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MS. CRONK: Q Well, Dr. Rose, to help  
you in that regard, Dr. Freedom testified that at the  
time of preparing his reporting letter to the  
referring physician in Manitoba he had not had the  
opportunity to review the medical record of the child.

A. Right.

Q. And that he had been informed  
that the child had been stable prior to his death  
and was of the view then that there had been a good  
response to the prostaglandin therapy that had been  
prescribed for the child?

A. That is right.

Q. He testified further, and this  
is in Volume 29, Mr. Commissioner, at page 5389 to





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5395, that once he had had an opportunity to review the medical record which he did after sending that reporting letter to the referring physician, he concluded that the child in fact had not been stable prior to his death and had not had a good response to prostaglandin therapy.

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A. He says the chart speaks for itself and he is correct.

9

10

Q. You are familiar with Dr. Freedom's evidence in that regard?

11

A. Yes.

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Q. Do you share his opinion, Doctor, that the child based upon the contents of the medical record does not appear to have had a good response to the prostaglandin therapy?

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A. Yes.

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Q. At the time of the child's death when you were called in after the arrest and after the resuscitation efforts, did you then in your mind formulate an opinion as to the child's cause of death as opposed to any discussions which you may have subsequently had with Dr. Freedom?

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A. Yes. I knew what the diagnosis was. I knew what treatment had been given. I knew the response was inadequate, and there was a good





D.14

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2 reason for this child - the child's death was  
3 adequately explained by its severe cardiac problem.

4 Q. Were you aware, Doctor, at the  
5 time of being called in at the arrest of Real Gosselin  
6 that evening before his death he had had a digoxin  
7 level of 3.7 nanograms?

8 A. Yes, I always check on  
9 medications. This is a routine. I knew that digoxin  
10 was held because of the high level. I knew that the  
11 child had been started on digoxin in Winnipeg, I  
12 believe, with a rather higher dose than we would  
13 normally give ourselves, a digitalizing dose. I knew  
14 about the level and I knew about the fact that digoxin  
15 was held, so I had no concerns about digoxin except  
16 that the child was in severe heart failure and the  
17 renal function might have been impaired. So there  
18 might have been a level around 3 or 4 and continuing  
19 after the digoxin was held.

20 Q. Well, based on the terminal  
21 events that the child in fact did suffer, Doctor, as  
22 they were described to you when you arrived at the  
23 Hospital, did you have any concern at that stage that  
24 digoxin might have contributed to the child's death?

25 A. Not really, no. It had been  
held for more than a day and the child had passed







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some urine which means the kidney had functioned to  
some extent. So I had no concern about digoxin at all.

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Q. All right. In your view, Doctor,

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were the digitalizing doses that had been prescribed

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and administered in Winnipeg sufficient to produce

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a toxic and lethal effect in a child?

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A. No, not at all.

9

Q. Right.

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A. There are some people who use

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higher doses than we do, and each child responds

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differently.

13

It always depends on the type of problem

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they have as to what the levels are in the blood. So

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I don't treat children based on their digoxin level.

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I told you that before, and it is very important for

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us to treat children for their medical problem, for

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their cardiac problem, and to teach the residents

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and doctors that we have to train to go out in the

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world and not to base their treatment on digoxin

levels because they may not have a digoxin level

available.

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Q. I understand, Doctor, but so

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that I am clear on this particular case, when you did

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arrive on the ward in accordance

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with your usual practice you checked the medications

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that had been prescribed and administered at The  
Hospital for Sick Children?

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A. Yes, that is correct.

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Q. And as well did you at that time  
review the digitalizing doses that had been prescribed  
for the child and administered in Winnipeg?

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A. Yes, because of the level that  
I saw.

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Q. All right.

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A. I wanted to be sure that the  
digoxin had been held based on that level.

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Q. And with that knowledge in hand  
and with the knowledge of how the child had died and  
the terminal events that he had sustained, you did not  
as I understand your evidence, have any concerns that  
the digoxin therapy had contributed to his death?

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A. None whatsoever.

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Doctor, the next child as I understand  
it with whom you had some direct involvement was that  
of Stephanie Lombardo who was admitted to the  
Hospital on December 13th, 1980 and who died on  
December 23rd, 1980.

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Once again, as I understand it, you  
were the cardiologist on call at the time of that  
child's death?





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A. That is correct.

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Q. All right. Do you recall,  
Doctor, attending physically at the Hospital at the  
time of her arrest?

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A. Not at the time of her arrest.  
I think I came later to speak to the parents and to  
review the chart.

7

8

Q. All right. Were you contacted  
by the attending physician or the resident at the time  
of the child's arrest?

10

11

A. I was contacted by the cardiology  
Fellow, Dr. Brand.

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Q. I am sorry?

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A. Dr. Brand.

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Q. Dr. Rowe has testified, Dr. Rose,  
with respect to the death of this child that initially  
there were questions amongst the cardiology staff  
as to the reason for Stephanie Lombardo's sudden  
decline and death but that the discussions after her  
death centred around the precarious nature of her  
shunt.

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A. Yes.

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Q. He expressed the opinion at  
Volume 15, Mr. Commissioner, page 2558, 2559, that the  
probable explanation for her death was thought to be







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occlusion of her shunt having regard to the fact that the shunt had been considered potentially precarious prior to her death.

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Is that a conclusion as to the probable cause of death to which you agree?

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A. Yes.

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Q. Right. He also testified, Dr. Rose, that immediately prior to her death in the evening before her death Stephanie Lombardo had apparently been stable. That is during the late evening hours of December 22nd.

12

A. Yes.

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Q. And that she then went into an immediate dramatic and rapid decline.

15

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Is that an observation concerning her terminal events and her status before the onset of terminal events with which you agree?

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A. I don't know what you mean by stable, but if that is written on the chart then somebody must have thought she was stable, but I think that is a mistaken notion based on what was going on before with this child.

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Q. So that we are clear, Dr. Rowe's testimony was that prior to the terminal events of the child in the latter part of the evening of





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December 22nd she appeared relatively stable. Was her condition that evening prior to the terminal events described to you when you were called in and when when you were contacted after her arrest?

A. No. It was only my review of the chart that indicated to me that she could not have been stable. She was blue. She did not have the murmur, the continuous murmur which we expect to hear when there is a shunt, and she had been very unstable as far as her response to heparin had been concerned, heparin being the blood thinner that was given to keep the shunt open. And this response to heparin was checked by looking at the blood prothrombin time and partial thromboplastin time. These are two measures of assessing the fluidity of the blood, and if you have read the charts recently, Dr. Jedeikin described these levels to be all over the place. In other words, very unstable, so that was certainly a concern, and the fact that there was no murmur would always concern me.

And if you write stable in a child that has no murmur, I think that is a very unstable situation in my view.

Q I see.

Having regard then to what you would





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have felt her condition to be that evening, were you at the time of her death surprised by the onset of these terminal events and the nature of the events that were sustained by her?

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A. No, I was not.

7

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Q. All right. Doctor, at the time of her death was any consideration to your knowledge given to reporting her death to the coroner?

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A. No. I think there was sufficient reason there for her death based on her problem, namely the patency of the shunt.

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I was concerned that there were notes on the chart to say that the shunt should be revised. This was discussed, and the opinion of the surgeon saying that he probably could not revise it, it would not be possible to revise it, and that all we could do was keep it open with heparin, and I was concerned that this maybe wasn't adequately explained to Mr. and Mrs. Lombardo. They seemed to be under the impression that the child was going along fine because it had been transferred to the ward.

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I am not sure what was said to the parents, but I know they were very upset and I sympathized with them.

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I explained to them that this could





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happen at any time. In some children we manage to maintain the patency of a shunt and in others it just goes like that.

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Q. You personally spoke then to Mr. and Mrs. Lombardo after the child's death?

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A. I did. I don't think they remember this. I think they thought I was a nurse and they wouldn't remember talking to me, but I did talk to them.

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Q. That sometimes happens, Doctor, I am sure.

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During the course of that discussion I take it from what you just said that you explained to them your view that the problem with the shunt, the occlusion of the shunt, may have been the factor that resulted in the child's death?

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A. Yes.







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Q. Dr. Rowe also testified, Dr. Rose, that having regard to the fact that Stephanie Lombardo was not known to have been prescribed digoxin, or administered digoxin in the Hosiptal for Sick Children, and yet on subsequent forensic tests digoxin was found in the tissues from her body, he expressed the view that having regard to those forensic findings and subject to the interpretation which pharmacologists may place on the interpretation of the digoxin levels. He felt it was possible that her death might have been caused by digoxin intoxication. Is that a view with which you agree, Doctor?

A. I think those are a lot of words. I think we have a lot to learn about digoxin and I don't want to say anything about this until we have heard from the pharmacologists.

Q. I appreciate your position on that.

Mr. Commissioner, for the purposes of the record, Dr. Rowe's evidence in that regard can be found at Volume 24, page 4309 to page 4310.

May I ask you this then, Doctor? I take it that at some point of the Stephanie Lombardo's death you became aware that forensic tests were





1  
2 carried out and that digoxin was found in quantities  
3 in her body?

4 A. Yes.

5 Q. Or in tissues from her body?

6 A. Yes.

7 Q. On the basis of your having  
8 heard that, was your degree of confidence in the  
9 cause of her death reduced in any fashion?

10 A. It was very difficult. I think  
11 I was still confident that she could have occluded  
12 her shunt and died suddenly but somewhat unexpectedly.  
13 However, the digoxin found in the tissues might have  
14 meant that she had an inadvertent dose, possibly a  
15 mistaken dose that was meant for someone else. I  
16 have no idea what they mean, whether they were toxic  
17 doses, or what they were, so I cannot comment further  
18 on the digoxin in the tissue post mortem.

19 Q. Thank you, Doctor. Following  
20 your initial discussion, I am sorry, following your  
21 discussion with the Lombardos, the evening of their  
22 daughter's death, did you personally have any  
23 subsequent discussions with them as to what had  
24 caused their daughter's death?

25 A. No, I think Dr. Rowe did.

Q. Doctor, the next patient with





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which you had some involvement as I understand it was Colleen Warner who was admitted to the Hospital on March 6th, 1981, and who died on March 7th on Ward 4A. Once again as I understand it you were ward chief at the time of the admission of this child, as opposed to the time of her death, is that correct?

A. I was on call the night she died.

Q. And in addition to that were you ward chief at the time of her admission?

A. I don't think so, I don't think so, it was March.

Q. Yes, 1981. Do you recall, Doctor, prior to her death having examined this child?

A. I am sorry?

Q. Do you recall prior to the time of her death having seen and observed, or examined this child?

A. I did not examine this child.

Q. So prior to her death I take it you had not personally seen the child.

A. I had not seen the child, no.

Q. Dr. Rose, I am showing to you







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what has been described to me as the contents of the  
zebra pack on Colleen Warner.

4

A. Yes.

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Q. I would ask you to look at it

6

if you would, and specifically at page 3, which is  
described as a "Report of Consultation", it has not  
yet been marked as an exhibit, Mr. Commissioner.

8

THE COMMISSIONER: This will be

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marked as Exhibit 190.

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---EXHIBIT NO. 190: Zebra Pack re Colleen Warner.

12

MS. CRONK: Q. Dr. Rose, I ask you

13

to turn to page 3 if you would of the zebra pack,  
do you have there a document described or entitled  
as "Report of Consultation - Colleen Warner"?

15

A. Yes.

16

Q. Is that your report, Doctor?

17

A. Yes.

18

Q. And as I understand it,

19

Doctor, from your evidence, you did not see the  
child prior to her death?

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21

A. No.

22

Q. I take it if you were on call

23

at the time of her death you were contacted when the  
child arrested?

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A. Yes.

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Q. Did you physically attend at

4

the Hospital prior to her death being pronounced dead?

5

A. No.

6

Q. I am sorry?

7

A. No.

8

Q. You did not?

9

A. No.

10

Q. Did you subsequently come in

that morning?

11

A. Yes.

12

Q. Or did you arrive at the

13

Hospital after she had died?

14

A. I came in in the morning, and

15

really I should have written this on a different

16

piece of paper, I did not physically examine the

17

child. The piece of paper I used, namely "Report

18

of Consultation" would normally mean that I had  
examined the child, I am just describing what happened.

19

Q. I take it then, Doctor, that

20

this description in this note was prepared after

21

the child's death?

22

A. Right.

23

Q. When you arrived at the

24

Hospital and then had an opportunity to review her

25





1  
2 medical record?

3 A. That is correct.

4 Q. And in the middle section of  
5 the note which you wrote, Doctor, there appears to  
6 be a differential diagnosis set out, a number of  
7 potential diagnosis?

8 A. Yes.

9 Q. You indicate the:

10 "Clinical findings: congestive failure  
11 with cardiomegaly; no murmur; ECG  
12 findings of heart rate; no  
13 P waves."

14 And then I see an indication under the differential  
15 diagnosis of:

16 "Cardiomyopathy with failure."

17 And is that then a question mark: "endocardial  
18 fibroelastosis"?

19 A. That is correct, that was  
20 the diagnosis on admission.

21 Q. And once again, Doctor, can  
22 you help us, was it suspected that Colleen Warner  
23 had a particular kind of endocardial fibroelastosis,  
24 was it the contracted or the dilated type?

25 A. It was the dilated type that  
was suspected.





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Q. And if I understood your earlier evidence, with that particular type of endocardial fibroelastosis there is a higher susceptibility, or a higher degree of risk to digoxin intoxication in a patient with that condition?

A. That is correct.

Q. Can you help us, Doctor, I take it that was a suspected diagnosis prior to her death?

A. Yes.

Q. It obviously had not been confirmed prior to her death?

A. No, but it was obvious on the echocardiogram that she had a very dilated heart, a poorly functioning chamber muscle.

Q. Doctor, can you help me, were any special procedures or steps taken with respect to her digoxin medication as a result of that diagnosis?

A. Yes.

Q. Can you help me as to what they were?

A. Reducing the dose.

Q. And if we continue in the balance of your consultation note, you have an







1  
2 indication of the notes at 7:00 p.m.?

3 A. Yes.

4 Q. You are referring to the first  
5 digitalizing dose, half a dose, and you continue to  
6 describe the doses that were prescribed. Do I  
7 correctly take it then, Doctor, that as a result of  
8 that diagnosis that she was in fact prescribed less  
9 than what would normally be considered the normal  
10 therapeutic dose of digoxin?

11 A. Yes.

12 Q. And that was as a result  
13 specifically of the concern that she might have a  
14 higher susceptibility to digoxin intoxication?

15 A. Yes.

16 Q. Dr. Rowe testified, Dr. Rose,  
17 before the Commission with respect to the death of  
18 Colleen Warner that on the evening of her admission,  
19 although she had earlier presented with severe  
20 congestive heart failure, it appeared from the  
21 medical record that she had improved during the  
22 course of the evening, is that an observation with  
23 which you agree?

24 A. That is correct, that is the  
25 reason I didn't come in because she had settled down,  
I was going to see her in the morning.





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Q. Well let me back up then,

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Doctor. You were on call the evening of her death.

4

Do I take it you were then on call at the time that

5

she was admitted as well?

6

A. Yes, it was Friday night and

7

it was my weekend on call.

8

Q. So you were called at the time

9

she was admitted?

10

A. Correct.

11

Q. And elected, based on the

12

description of her condition at that time, not to

13

come into the Hospital as she appeared to be improving.

14

A. Actually when I was first

15

called I was prepared to come in because I felt a

16

heart rate of 240 was a bit too fast and if she wasn't

17

going to settle I was going to come in and see if

18

we could take steps to reduce that. Then I was

19

called again by Dr. Ning and Dr. Schaffer to tell

20

me that the child had settled and gone to sleep and

21

was more comfortable and I didn't want to disturb her

22

knowing that the diagnosis was.

23

Q. So on that basis you didn't

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come in at that point?

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A. That's right.

Q. And then subsequently you were





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contacted again, was it by Dr. Ning or Dr. Schaffer?

A. Dr. Ning.

Q. That was at the time the child sustained a cardiac arrest?

A. Yes.

Q. Dr. Rowe further testified that although she had improved that evening, in the course of the evening following her admission, that her terminal events commenced in his view suddenly and proceeded rapidly?

A. Yes.

Q. Was that an observation with which you would agree?

A. Yes.

Q. And finally he testified that the terminal events themselves, their onset and their course were consistent both with digoxin intoxication and in his view were also consistent with the child's anatomical and clinical condition?

A. Yes.

Q. Do you share both of those views?

A. I do.

Q. Do you have anything further that you would like to add with respect to her death, Doctor?







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A. No.

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Q. Can you tell me, Doctor, given the suspected diagnosis of endocardial fibroelastosis and given the precautions that were taken in reducing the doses of digoxin that were administered, did you when you were called at the time of her arrest have any concerns that digoxin might have contributed to her death?

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A. I think she might have been more sensitive even than we thought, there is always the possibility.

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Q. Was that a matter that was of concern to you when you were called that she had arrested?

A. Yes. In fact when I came in the following day we went over the doses very carefully, with the residents, the two doctors, Dr. Schaffer and Dr. Ning, because I was concerned, and to make quite sure that the dose had been adequately reduced. I had concern about the amount of digoxin that this child received. When we reviewed the chart we found they were entirely appropriate and then I had no further concern after we had that discussion.

24

25

Q. Doctor, once again, do you





1  
2 recall attending a meeting on November the 9th, 1982  
3 with Constable John Murray and Constable Margo  
4 Pulford of the Metropolitan Toronto Police Force  
5 at which the death of Colleen Warner was discussed?

6 A. Yes.

7 Q. Do you recall that?

8 A. Yes.

9 Q. Do you recall as well  
10 expressing the opinion at that time that the baby's  
11 death had come as a surprise to you as well as to  
12 Dr. Ning and Dr. Schaffer who had examined her  
on admission at the Hospital?

13 A. The surprise was related to  
14 the finding of ventricular septal defect which we  
15 had missed on the echocardiogram. If the child had  
16 just had a ventricular septal defect we wouldn't  
17 have expected her to succumb during the digitalization  
18 process. I had expressed the concern that there  
19 was an additional myocardial insult, in other words  
20 the child might have had some myocarditis or  
21 inflammation of the myocardium as a result of a viral  
22 illness and so on and that tipped the balance in  
23 this case. My concern was that if she had just had  
24 a hole in the heart she should not have died during  
25 digitalization process.





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Q. And I take it, Doctor, when you say the ventricular septal defect was missed during life, that that was a matter that was subsequently disclosed at autopsy?

A. Yes.

Q. And when the autopsy results were made available: well, first, Doctor, do you recall seeing a copy of the preliminary autopsy report on Colleen Warner?

A. No, I recall seeing the heart?

Q. Did you personally observe the heart at gross autopsy?

A. Yes.

Q. And based on your observation of the heart, and based on the results ultimately of the autopsy itself, were you satisfied that there was a reasonable explanation based on her anatomical condition for her death?

A. Yes, very much so.

Q. And did you attribute it then I take it both to the disclosure and to the existence of the ventricular septal defect as well as to the congestive heart failure that she presented with the night of admission?

A. And also that she had at





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autopsy cytomegalovirus infection of several parts  
of her body and also affecting the myocardium and  
this contributed to her death I am sure.

Q. I take it then, Doctor, that  
following the autopsy results and following your  
observations at gross autopsy, would it be fair to  
say that you were not concerned as to the cause of  
this child's death?

A. No, not at all.

MS. CRONK: Mr. Commissioner, I am  
about to move to a new area.

THE COMMISSIONER: All right, 20  
minutes.

---Short recess.

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---Upon resuming.

THE COMMISSIONER: Yes, Ms. Cronk.

MS. CRONK: Thank you, Mr. Commissioner.

The next child that I understand you had some direct involvement with, Dr. Rose, is Jordan Hines.

Perhaps, Mr. Registrar, you can provide Dr. Rose with Exhibit 103, which is the medical record, and as well with 103 A and B; 103 A, Dr. Rose is the final autopsy report on Jordan Hines and 103 B is the zebra pack of Jordan Hines.

A. Yes. Actually, I have it, I have the zebra pack.

Q. Right. Doctor, we know that Jordan Hines was admitted to the Hospital for Sick Children on March 6th, 1981 and that he died on March 8th, 1981, as it happens the day after the death of Colleen Warner. As I understand it, you were on call on the evening of Jordan Hines's death, is that correct?

A. That's correct.

Q. All right. You were contacted I take it then at the time of the arrest by the cardiology fellow?

A. That's correct.

Q. Did you attend at the hospital,





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Doctor, prior to the child's pronouncement of death?

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A. Yes. I saw the child on my ward

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round the day before he died, a day or two days before

5

he died.

6

Q. All right.

7

A. On the Saturday, whichever date

8

that was.

9

Q. Well, in addition to that, Doctor,

10

at the time that you were contacted by the cardiology

11

fellow concerning his arrest, did you then come into  
the hospital?

12

A. Yes I did.

13

Q. All right. And did you arrive

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before the child was pronounced dead?

15

A. Maybe just before, yes.

16

Q. Do you recall being there while

17

the resuscitation efforts were still under way?

18

A. Yes.

19

Q. All right. Dr. Rowe testified

20

with respect to Jordan Hines, Dr. Rose, that at the

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time of his death and at the morning cardiology

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conference which followed that day, the cardiology

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division were not sure what the cause of death was.

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I would like to direct your attention then in point of

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time to the time immediately after his death and the





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morning cardiology conference. At that time, Doctor, had you formulated an opinion as to the cause of death of Jordan Hines?

A. Yes.

Q. All right. And what was your opinion at that stage?

A. My opinion, based on his history and physical findings, was that he could have had some myocardial involvement with a viral illness and resultant irregularity of the heart rythmn.

Q. Right. Now, in addition to the - I take that to be what has been described to us as myocarditis, an inflammation by way of viral infection of the heart muscle.

A. Yes, inflammation, yes.

Q. Is that correct?

A. Yes.

Q. All right. In addition then to the suspicion that that might have been the cause of his death, did you at that stage, either at the time of his arrest or at the morning cardiology conference that day, did you entertain any other possible cause of his death?

A. No.

Q. All right. As I understand it,







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Doctor, we have heard evidence that you attended at the gross autopsy of Jordan Hines and physically observed the heart, is that correct?

A. That's correct.

Q. Was it your normal practice to do that, Doctor, in respect of patients for whom you had cared or in whose care you had participated?

A. Yes, especially if I had some concern about the cause of death. There was no structural heart disease in this child, so, I did have some concern.

Q. All right. And that was why in the instance of Jordan Hines that you made a point to go and actually observe the heart.

A. That's correct.

Q. Now, at the time of the gross autopsy, Doctor, when you had observed the heart, did your opinion with respect to the probable cause of death, that is, the suspicion of viral infection or myocarditis, was that confirmed in your view based on your observations of the heart and the gross autopsy?

A. Not entirely because the child's heart was not enlarged, that was what we would normally see in a child with myocarditis. However, the heart muscle was extremely pale and there were some





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1  
2 hemorrhages on the lining of the heart and this could be  
3 consistent with a myocardial involvement in a viral  
4 illness. So, I required further studies of that  
5 particular aspect; microscopy in fact.

6 Q. I'm sorry, microscopy?

7 A. I had to await the microscopy,  
8 the microscopic examination which would then show  
9 further changes if it were indeed a viral illness that  
10 had affected the heart muscle.

11 Q. Right. And I take it that the  
12 microscopic examination was something that would be done  
13 as part of the full autopsy on the child?

14 A. Right, that's correct.

15 Q. Right. And was there a particular  
16 part of the body, be it the heart or any other organ  
17 that was to be examined to the best of your knowledge  
18 for the purposes of determining whether or not  
19 infection had caused his death?

20 A. I think there would have been an  
21 overall examination of all the organs as part of the  
22 autopsy and I knew that this would be very carefully  
23 done in this case by the pathologists who are very  
24 excellent in this regard and I knew that they would  
25 come up with an answer but that it would take time.

Q. Right. At the time, Doctor,





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that you observed the heart at gross autopsy, I take it that the pathologists who were going to conduct the autopsy were present at that time?

A. Yes.

Q. All right. Was there any discussion between you and the pathologists who were going to conduct the autopsy as to the probable cause of death at that stage?

A. No. I think they would never commit themselves until they had done a full autopsy and known everything that there was to be known.

Q. All right. To the best of your knowledge, from a purely clinical assessment or perspective, was there anything that presented itself at that stage as a probable cause of death other than the possibility of the viral infection to the heart or the myocarditis?

A. I had the doctor's, the referring doctor's note and he questioned the possibility of a sick sinus syndrome. This is a condition where there is some dysfunction of the sinus node which is a sort of a pace-maker of the heart. The reason he thought this was because the child had had some episodes of bradycardia and some episodes of tachycardia. He also wondered if there could be a cardiac tumor giving





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rise to this type of rhythm disturbance. That latter part had been ruled out on the basis of the echocardiogram, but in any event I wanted to see it for myself. It could still have a tumor within the myocardium that you could not detect on echo but that was ruled out at gross autopsy.

Q. Right. So that I understand it then, Doctor, by the time the gross autopsy was conducted there were three possible explanations of which you were aware?

A. Yes.

Q. The first was the issue of myocarditis and you have told us that that, in order for that to be confirmed or ruled out it required microscopic examination.

A. Right.

Q. Right. The second was the possibility of a cardiac tumor which had originally been raised I take it by the referring physician.

A. That's correct.

Q. Right, and that is the referring physician outside the Hospital for Sick Children?

A. Yes.

Q. And you have told us that that







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was ruled out in part by the echocardiogram.

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A. Yes.

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Q. But it was confirmed as not being

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the cause on the basis of the heart itself at gross

6

autopsy.

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A. Right.

8

Q. Right. And the third possibility

9

that you have indicated was the earlier suggestion of

10

sick sinus syndrome?

A. Yes.

11

Q. Do I take that correctly to be

12

involving some dysfunction of the conduction system?

13

A. Yes, that's right.

14

Q. The electrical conduction system?

15

A. Yes, that's right.

16

Q. Right. And was there anything

17

that presented itself at gross autopsy based on your

18

own observations that helped in either confirming that

19

as a condition which the child had or in ruling it out?

20

A. No, you cannot tell this at all

21

on the gross autopsy, there is no way of finding out,  
it would have to be an electrical study of the heart.

22

Q. All right. And is that what has

23

been referred to, Doctor, as the conduction study?

24

A. A conduction study during life,

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a study of the conduction system, an electrical study of the conducting system. But it has never been done in a young baby, so, it is a very difficult thing to do.

Q. All right. So that I understand it then, Doctor, the existence of, or at least confirmation of the diagnosis of sick sinus syndrome was something that could then have been achieved during the life of the child had a study of the electrical system been undertaken at that time?

A. Yes, that's correct.

Q. All right. But I understood you to say that that would be a rarity with young children?

A. Yes. I don't think it has ever been done in a child of this age.

Q. All right. What then at the time of the gross autopsy was there if anything that could be done to determine at that stage after death whether or not the child had a conduction system disorder that accounted for his death?

A. I think microscopy is what we would need, but a study of the conduction system isn't usually done on a routine basis and I don't think there was anybody available to do this type of a study





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1  
2 in any event.

3 Q. All right. After the gross  
4 autopsy, Dr. Rose, did you discuss the findings or  
5 your observations at gross autopsy with Dr. Fowler?

6 A. Yes.

7 Q. I'm sorry, you did?

8 A. Yes, yes, I did.

9 Q. Right. And were they discussed  
10 as well at the morning cardiology conference on the  
11 day of Jordan Hines' death?

12 A. I think we made everyone aware  
13 of what the gross findings were. We usually do this  
14 when a child dies and usually it is Dr. Freedom who  
15 informs us what the gross findings were.

16 Q. Yes.

17 A. And so we talk about what they  
18 were and what else we might be looking for in this  
19 child.

20 Q. Right. Well, can you help me,  
21 Doctor, was there anything that presented at gross  
22 autopsy or anything that arose during the discussions  
23 at the morning cardiology conference which suggested  
24 Sudden Infant Syndrome at that stage as a possible  
25 cause of this child's death?

A. Not at that stage.







F.11

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2 Q. Not at that stage, all right. I  
3 take it then that the two possible explanations at that  
4 stage as you have described them were the myocarditis  
5 and possibly a conduction system disorder having to  
6 do with the sinus node?

7 A. Yes. Myocardial involvement in  
8 a viral illness because it wasn't a true myocarditis.  
9 The mother had had a viral infection and so had the  
10 sibling and the child had some pneumonitis and some  
11 rhythm disturbance. So, that would all fit very well  
12 with this myocardial involvement in viral illness and  
13 we don't necessarily call this myocarditis.

14 Q. I see, all right. Would  
15 myocarditis per se have been evident on physical  
16 examination of the heart?

17 A. I think if the child had had  
18 true myocarditis he would have been in some degree of  
19 heart failure, he would have had an enlarged heart,  
20 he didn't have that.

21 Q. I see, all right. So, the  
22 suspicion then was related to involvement of viral  
23 infection?

24 A. Yes. It was a rare type of  
25 viral myocarditis which leads to lethal dysrhythmias  
and it is rare and we have seen one or two cases. In





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fact, we started looking up the literature, it is called oncolytic myocardopathy and we reviewed some reprints, the fellows and I, just to look and see if that child might fit into that type of a slot.

Q. And was that what you suspected might have been the case?

A. That's what I wanted to rule out.

Q. I see.

A. By the microscopy.

Q. Now, Doctor, at the time of the gross autopsy I take it obviously the parents had been first informed of the child's death and secondly had given their consent to the autopsy?

A. Yes.

Q. All right. At that stage, Doctor, was any consideration, to the best of your knowledge, given to reporting the death of this child to the coroner?

A. No. As soon as we knew that the parents had given their consent, or as soon as I knew that consent had been given, I was satisfied that we would get all the information we needed and it was my judgment at the time that this was sufficient, that our expertise in the pathology department would be enough to come up with an answer in this case.





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Q. Do I correctly take it then Doctor that it was your intention to await the outcome of the full autopsy results, or at least the preliminary autopsy report before considering the reporting of the death to the coroner any further?

A. It never crossed my mind to inform the coroner about this case when I had consent for the autopsy. But I think if I had not had consent for the autopsy I would certainly have called the coroner in order to get an autopsy done, but not because I was suspicious about anything. It was merely to make sure that we have an autopsy. I thought it was very important to have an autopsy on this child.

Q. And that was because I take it of your concern that viral infection either be confirmed or ruled out?

A. Yes, that is correct.

Q. All right, Doctor. Now, following the conduct of the gross autopsy itself were you subsequently made aware of the results at the preliminary autopsy, that is, the actual dissection of the heart?

A. Not for a long time. In fact, I tried to get the results but unfortunately after the dreadful events of the end of March the chart was





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removed, the heart was removed and I was told there was no way I could get any information and it disturbed me a lot I must say. It disturbed me not only for the reason that I couldn't see it but it disturbed me that we were not able to give the parents any information as to what the pathology showed and I think they needed a preliminary idea. In fact, I wrote them a letter, and you may have this in evidence, dictated on April 3rd, in which I expressed my regret about the events that had occurred at the end of March and that I assured them that as soon as we had any information they would be so informed.

Q. All right. Well, Doctor, if we could take that in two stages. At the time of the child's death and following gross autopsy did you have any discussions with Mr. and Mrs. Hines?

A. No. No, I felt it was inappropriate because I did not have a complete report.

Q. All right. You have said then that you tried to obtain subsequently a copy of the preliminary autopsy report, that you were waiting for it. Could I ask you to turn to page 29 of the medical record if you would?

A. All right.









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Q. Do you have that, Doctor?

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A. Yes.

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Q. That's a copy of the preliminary

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autopsy report that was ultimately prepared.

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A. Yes.

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Q. Can you help me Doctor as to

when you first saw a copy of that report?

8

A. I think I saw this first when

9

the Police Officers showed me the chart of Jordan

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Hines, and that was many months later.

11

Q. All right. Do I take it then

12

that the first time you saw either the - the first

13

time you saw the preliminary autopsy report was after

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the Metropolitan Toronto Police had become involved

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in the matter, which we know was on the weekend of

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March 22nd?

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A. Oh, much, much later than that.

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Q. Much, much later than that.

18

A. In fact, I think it was even

19

after Dr. Harry Bain had written his report and I

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know he had the autopsy available. I realize that

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after the events of the end of March there was no way

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of my even trying to get any reports because I was

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told there was no way I could see the chart, I could

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learn anything about the autopsy findings. So, I must

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say I gave up at that point, there was no way.

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Q. Well, Doctor, quite apart from being able to obtain and review a copy of the preliminary autopsy report itself, were you orally informed by the pathologists involved as to what the outcome had been following the preliminary autopsy?

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A. No. I tried to find out from them what the microscopy showed.

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Q. Yes.  
A. They told me it would be many weeks before they would have it in detail and they said the heart had been taken away and the records had been taken away and since it was now a coroner's case I had no access to any of this information in any event. So, I must say I didn't pursue it any further.

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Q. All right. Do you recall Doctor which pathologist you spoke to in an effort to be informed as to the results of the preliminary autopsy?

A. The pathologist who usually works with us in cardiology is Dr. Greg Wilson. I am not sure if he told me if it was Dr. Becker who did the autopsy or not but he may have done at the time.

Q. Do you recall today having had any discussions with Dr. Becker, quite apart from





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having been provided with a copy of the preliminary autopsy report, do you recall discussing with Dr. Becker what the results of the preliminary autopsy, the dissection of the heart and the examination of the other organs had been?

A. Not at the time but I have talked to him since.

Q. All right. Let's deal then Doctor if we could for the moment with the final autopsy report which is Exhibit 103 A. Do you have that, Doctor?

A. Yes.

Q. Do you recall being provided with a copy of the final autopsy report, Doctor?

A. Yes, by the Police Officers with the chart when they came to see me.

Q. All right.

A. That's the time that I saw it.

Q. And was that the same time that you were provided with the preliminary autopsy report?

A. I don't remember. But whatever was on the hospital chart I saw, it could have been the same one.

Q. I take it then that prior to that meeting with representatives of the Metropolitan





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Toronto Police Force you have no recollection of seeing either the preliminary or the final autopsy report on Jordan Hines?

A. No.

Q. All right. Do you have any understanding, Doctor, as to when those reports were in fact available from the pathology department?

A. No.

Q. All right. With respect to the preliminary autopsy report, Doctor, if I could refer your attention to the final paragraph. That is at page 29 of the record.

A. Yes.

Q. The final full paragraph on page 29. The results of the preliminary autopsy are set out in that paragraph. The first indication is that:

"At autopsy, the heart looked normal grossly and microscopically."

A. That's correct.

Q. There is then a recitation of a number of factors including congestion in the lungs, including:

"... fibrous thickening of the pulmonary arterials suggesting chronic







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"hypoxia. Persistence of brown fat was also seen in the autopsy. The brain showed gliosis in the brainstem... persistent extra-medullary --- "

And I may pronounce this incorrectly, Doctor ---  
"hematopoiesis."

A. Yes, very good.

Q. I take that to be a growth of blood cells outside, as I understand it, the bone marrow, and unexpected sites within the body.

A. Very good.

Q. Is that correct?

A. That's correct, yes.

Q. Thank you, Doctor. The persistence of brown fat is repeated and then the thickening of the pulmonary arterials is repeated again. That is then described in the next sentence as:

"This pathologic evidence, in conjunction with the clinical history, makes the diagnosis of a missed-SIDS a possibility. However, this does not explain the arrhythmias and further conclusions will have to await examination of the conducting system. There was no evidence of infection in





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"the autopsy."

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Stopping there, Doctor. First, as I understand it, based on the preliminary autopsy report, there was no suggestion at that stage a cardiac tumor, that indeed as you have told us was ruled out at the time of gross autopsy.

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A. Yes.

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Q. There is also an indication that there was no evidence of infection at the autopsy.

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A. Correct.

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Q. Doctor, can you help me, would the microscopic examinations which you indicated would be required to rule out the possibility of viral infection be the type of investigation conducted at the preliminary autopsy stage or is that a matter that would have been conducted when the full autopsy was performed?

A. The microscopy is usually done or reported at the final autopsy report, but it all depends on when they looked at the slides. They might have looked at the slides and reported the findings in the preliminary report. It is really up to the pathologist.

THE COMMISSIONER: So I understand it, there is really only one autopsy? Am I not right?

THE WITNESS: That is right.

THE COMMISSIONER: There may be a preliminary or a final report. I think you phrased your question --

MS. CRONK: Perhaps I misled in the way I phrased it.

THE COMMISSIONER: -- that there were two operations.

MS. CRONK: Q. As I understand it,





1  
2 Dr. Rose, and perhaps you can confirm this, that there  
3 are a number of stages that are gone through in  
4 completing the full autopsy?

5 A. Right.

6 Q. And at some stage, as those  
7 steps are completed, a preliminary autopsy report is  
8 prepared?

9 A. Yes.

10 Q. And then when the full  
11 autopsy has been completed the final autopsy report  
12 is prepared?

13 A. That is right.

14 THE COMMISSIONER: I'm sorry, I don't  
15 - perhaps that is right but that is not quite the  
16 way I understood it.

17 I understood it takes a while perhaps  
18 before you have the results, but you just perform one  
19 autopsy.

20 THE WITNESS: Absolutely, yes.

21 THE COMMISSIONER: How long does  
22 that take?

23 THE WITNESS: Well, a microscopy  
24 examination usually takes a few weeks because what  
25 is done, and Dr. Becker will describe what he does  
much better than I do, but they take little sections







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of the heart --

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THE COMMISSIONER: Yes. Whatever  
4 is done to the body is done at one time, is it not?

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THE WITNESS: That is right.

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THE COMMISSIONER: It is a question  
7 of the time you take for the examination?

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THE WITNESS: That is right. A gross  
9 autopsy gives you major findings. The final autopsy  
10 gives you minutiae as it were about the detailed  
findings in the pieces taken from the heart --

11

THE COMMISSIONER: You don't  
12 dissect the body any further?

13

THE WITNESS: No, no.

14

THE COMMISSIONER: It is merely  
15 the parts are examined --

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THE WITNESS: In more detail.

17

THE COMMISSIONER: And perhaps some  
18 things will take weeks?

19

THE WITNESS: Right.

20

MS. CRONK: Thank you, Mr. Commissioner.

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Q. I take it then, Doctor, that  
22 the microscopic examination which you felt was  
23 required to rule out the possibility of viral  
infection was something that had been done by the  
24 time the preliminary autopsy report was prepared  
25





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2 because in that report we see the statement that there  
3 was no evidence of infection evident at the autopsy.

4 A. This report to me looks more  
5 like a final report. Normally in the preliminary  
6 report we would not see that much detail about the  
7 examination of the arterials, the brown fat, all this  
8 tends to be reported in a final report.

9 Q. Well, to help you, Dr. Rose,  
10 the evidence to date is that the final autopsy  
11 report and the preliminary autopsy report with the  
12 exception of a date which appears on the final  
autopsy report are virtually in substance identical.

13 A. Yes.

14 Q. Do you have knowledge,  
15 Doctor, as to whether or not the preliminary autopsy  
16 report and the final autopsy report were prepared  
17 contemporaneously in point in time?

18 A. I have no information but it  
makes sense that this is indeed the final report.

19 Q. All right. Well, we know that  
20 there is a document entitled final autopsy report --

21 A. Yes.

22 Q. -- Doctor, and I was just  
23 wondering if you could help us as to whether or not  
24 in this case there was in fact a time interval  
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between the preparation of these reports or whether because of the detailed nature of the preliminary autopsy report it would appear they were both prepared on or about the same time?

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A. Yes.

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Q. I take it you can't help me with that?

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A. No, I can't.

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Q. Doctor, with respect to the suggestion contained in the last paragraph of the report that there were a number of pathological indicators or pathological evidence in conjunction with the clinical history which led the pathologist to indicate that the diagnosis of a missed SIDS was a possibility, can you help me, Doctor, as to what you understood the pathologist to have concluded when you had an opportunity to review this report?

18

19

What did you understand the opinion of the pathologist was as to the probable cause of death at that stage?

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A. I think he noted that his findings were consistent with the possibility of this being a missed SIDS, eventually becoming a SIDS because of his findings which he has described.

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He had some concerns about arrhythmias.





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I don't think he was aware of the nature of these arrhythmias, but he just had the information that the child had some fast rhythms as well as some slow rhythms and he felt that the fast rhythms were not consistent with a diagnosis of SIDS.

Q. Doctor, when you were provided with a copy of the preliminary autopsy report was that the first time that you had heard the suggestion of Sudden Infant Death Syndrome as a possible explanation for this child's death?

A. I heard it from Dr. Bain, Dr. Bain's report. I had heard that Dr. Bain had carefully reviewed all the cases as an independent pediatrician with great experience in this area, and that he had felt, based on the autopsy report which was available to him and the clinical history and findings that this was a very classical case of a missed SIDS. I think he felt that very, very strongly, and I respect his opinion because he is an expert in that field.

Q. Well, we know, Doctor, that Dr. Bain prepared his report in the summer of 1982.

A. Yes.

Q. After the conclusion of the preliminary hearing involving Susan Nelles.







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A. Yes.

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A. That is correct.

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Q. Do I take it then that prior to the preparation by Dr. Bain of his report you had not been told nor participated in any discussion which suggested that Sudden Infant Death Syndrome was a possible explanation for this child's death?

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A. Yes.

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A. That is right.

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Q. And similarly, it would appear that the pathologist who prepared the report, and we know that it was signed by Dr. Becker, appears to indicate that there was some explanation required for the arrhythmias that had been experienced by the child?





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A. Right.

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Q. And he further indicates

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that further conclusions would have to await

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examination of the conducting system.

6

Prior to being provided with a copy

7

of the preliminary autopsy report by the police,

8

Doctor, were you aware that it had been proposed to

9

perform or undertake a study of the conducting

10

system on the body of Jordan Hines?

A. No.

11

Q. To the best of your knowledge,

12

Doctor, in respect of any patient in whose care you

13

have participated at the Hospital for Sick Children

14

has such a study ever been undertaken?

A. Never to my knowledge.

15

Q. Right. Can you help us,

16

Doctor, to you have any knowledge as to why the

17

conducting system in this case, because we understand

18

it was not in fact carried out, can you help us or

19

do you have any knowledge as to why it was not done

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in respect of Jordan Hines?

A. I think it probably was because

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we have no experts in this field at the present time

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available. There was only one pathologist at the

23

Toronto General who was doing such studies. And

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25





1  
2 the pathologist who would have been able to do such  
3 a study was appointed much later.

4 I think he is now in the department.  
5 I don't think there was anyone at the time who would  
6 have been able or would have had the expertise to  
7 do the study. So that is probably why it wasn't done.

8 Q. I take it then as far you are  
9 aware Dr. Becker could not have undertaken that study?

10 A. No.

11 Q. Nor anyone else in the  
12 Pathology Department at that time to the best of  
13 your knowledge?

14 A. Right. It would require  
15 somebody with considerable expertise to do this  
16 type of study.

17 Q. You indicated as well,  
18 Doctor, that when you attempted to obtain the results  
19 of the post mortem and the details of the postmortem  
20 examination on the body you were informed that you  
21 could not have access to the records; that it was  
22 now a coroner's case?

23 A. Right.

24 Q. And I believe you said that  
25 the heart had been removed from the Hospital?

A. That is what I was told.





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Q. Do you know, Doctor, when that occurred or were you told when that occurred?

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A. I was not told the precise time but it was all part of the police investigation I was told.

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Q. Right. So I take it it would have been some time on or after then March 22nd, 1981?

8

9

A. Yes.

10

Q. Doctor, with the preliminary autopsy report in hand in 1982, and having reviewed Dr. Bain's report.

11

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A. Yes.

13

Q. At that time -- it was prepared that summer -- were you satisfied at that time that the death of Jordan Hines had been adequately explained?

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A. I think so, yes.

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THE COMMISSIONER: Sorry, what was that answer?

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THE WITNESS: I think with the history of this child and the autopsy findings it all seemed to fit the Sudden Infant Death missed SIDS leading on to SIDS. With that information - you asked me about information.

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MS. CRONK: Q. Yes, I did. You told

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2 me that the first time that you had any indication  
3 of SIDS as a possible explanation for this child's  
4 death was in Dr. Bain's report?

5 A. Yes.

6 Q. Which we know wouldn't have  
7 been available to you until he had completed it or  
8 at least undertaken it in the summer of 1982.

9 My question to you was at the time  
10 you had that report in hand and at the time when  
11 you were subsequently shown the preliminary autopsy  
12 report by the Metropolitan Toronto Police, were you  
13 of the view that this child's death had been  
adequately explained?

14 A. I think it had been well  
15 explained by the autopsy findings plus the clinical  
16 history.

17 Q. All right. Well, Doctor,  
18 can you help me as to what in the clinical history  
19 of Jordan Hines in your view was suggestive of SIDS?

20 A. The child was - had had an  
21 episode of what appears to be apnea, which he had  
22 to be resuscitated by the mother. This is often  
23 the picture that we see in missed SIDS where a child  
24 is found apparently not breathing by a parent and  
25 has to be shaken.





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3 The child subsequently had three or  
4 four episodes of apnea and bradycardia.

5 The tachycardia that he had, if I  
6 looked at it, is not of the nature of an abnormal  
7 tachycardia. It is what we call a sinus tachycardia  
8 with a rate of up to 180, and this is visible in  
9 many children. This is apparent in many children  
10 at times. So I wasn't too concerned about this  
11 being an abnormal fast rhythm.

12 The child also had a respiratory  
13 infection. In fact he was congested and he coughed  
14 and he had nasal congestion and mucus, if you read  
15 the chart, and we know that SIDS is often precipitated  
16 by upper air obstruction in such a child.

17 The child was very lethargic. That  
18 is another point, and reading around the subject -  
19 it is not that I am an expert; I think you will hear  
20 from the experts on SIDS and there are many around -  
21 to me that seemed to be a good explanation for the  
22 death of this child. In conjunction with the  
23 pathologic findings which Dr. Becker described.

24 Q. Doctor, at the time that both  
25 of those reports were available to you I take it you  
knew that the language of the preliminary autopsy  
report raised missed SIDS as a terminal diagnosis?





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A. Yes.

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Q. As a possibility?

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A. Yes.

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Q. Did you in your understanding

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of that report, Doctor, conclude that Dr. Becker was

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satisfied that that was in fact the cause of death

8

of this child?

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A. I think the reason he wasn't

10

quite satisfied is that he thought the tachycardias

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were of a different nature. I think he felt that

12

this was an abnormal tachycardia of some kind like

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supraventricular tachycardia or ventricular tachy-

cardia, which in fact it wasn't.

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I think had he known about the type

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of rhythm disturbance the child had he might not have

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used the word "possibility". He might have said this

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was - although there is always a question in every-

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body's mind about SIDS. It is not - it's a clinical

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entity although there are the pathologic changes

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that we know about. It is still not a very definite

type of disease.

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We know, Doctor, that in addition

22

to describing missed SIDS as a possible or as a

23

possibility as a terminal diagnosis, Dr. Becker

24

expressed concern as to how the arrhythmias experienced

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1  
2 by the child could be explained.

3 A. Right.

4 Q. Do I take it from what you  
5 have just said that you interpreted that sentence  
6 to be an expression of concern by Dr. Becker concern-  
7 ing the tachycardia experienced by this child?

8 A. Yes, because tachycardia  
9 isn't usually described although there are isolated  
10 cases that have brady and tachycardia.

11 He had a question about that, and  
12 it is --

13 MR. ORTVED: Mr. Commissioner,  
14 just in relation to Miss Cronk's question about  
15 missed SIDS as a possible terminal diagnosis, that  
16 is not the way I read the report.

17 I read that paragraph as referring  
18 to the earlier episode in the child's history as  
19 being a possible missed SIDS with a diagnosis as the  
20 terminal cause of death being query Sudden  
21 Infant Death Syndrome.

22 MS. CRONK: I see, Mr. Ortved.  
23 Well, that is why I asked the Doctor whether or not  
24 she reached the conclusion that the language of the  
25 report suggested SIDS as a possible terminal diagnosis.  
And I had understood the Doctor to say yes.







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Q. Perhaps I can ask you again, Doctor: in your view when you received and were provided with a copy of the preliminary autopsy report what in your view was the cause of death that was being postulated by the pathologist on the basis of this report or did you think one was being put forward at all for the child?

A. I think the cause of death postulated was SIDS.

Q. And was that at the time based on the preliminary autopsy report in your view postulated as anything higher than a possibility?

A. I don't see what you mean by "higher than a possibility".

Q. In your view, based on the preliminary autopsy report, were you of a view that the Pathology Department had concluded that SIDS was the cause of death of this child, or was it merely a possibility as far as you were concerned?

A. I think - I told you what his question was, and he used the word "possibility". But I think he put enough information here as to his findings, and Dr. Becker is an expert so I would go along with his knowledge and expertise in the field of Sudden Infant Death Syndrome and believe him





1  
2 when he suggests this child could have died with  
3 SIDS.

4 Q. Well, Doctor, fairly I was  
5 interested only in your understanding when you  
6 received the report as to what had been concluded.

7 A. Yes.

8 Q. If anything, as to the cause  
9 of death.

10 A. Well, I understood that he  
11 concluded that SIDS was the possible cause of death.

12 Q. Thank you. And with respect to  
13 the question of arrhythmias, we know that on the  
14 basis of the clinical history of the child that  
15 the child had experienced periods of bradycardia,  
16 tachycardia, and during the course of his terminal  
17 events experienced ventricular fibrillation as well  
18 as reversion to a regular rhythm and then back again  
19 to ventricular fibrillation.

20 A. Yes.

21 Q. Do I understand from your  
22 evidence that as far as you were concerned reviewing  
23 the preliminary autopsy report, the arrhythmias that  
24 were called into question related only to the  
25 tachycardia that had been experienced by the child?

A. I think so.





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Q. Right.

THE COMMISSIONER: That answer was  
I think so, was it, Doctor?

THE WITNESS: Yes.

MS. CRONK: Q. Would you agree with  
me, Doctor, am I correct in my understanding that  
ventricular fibrillation itself is an arrhythmia?

A. It is.

Q. And similarly, bradycardia  
which is a slowing down of the heart rate can be  
described as an arrhythmia?

A. Yes. It depends whether it is  
a sinus bradycardia or whether it is a blocked  
rhythm. I mean text books have been written on  
rhythm and I don't think I want to go into this in  
great detail. I think if you just take that there  
is a fast rate and a slow rate that is full enough.

Q. Would you agree with me this  
far, Doctor, that it is possible that the term  
arrhythmias as used in the preliminary autopsy  
report could extend both to the tachycardias that  
the child had experienced and as well the bradycardias  
and the ventricular fibrillation which was apparently  
exhibited at the time of his death?

A. It could I suppose, yes.





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Q. Doctor, with respect to the indications which you have described and the clinical course of the child as being suggestive of Sudden Infant Death Syndrome --

A. Yes.

Q. -- as I understood the description of those symptoms or factors which you consider relevant, you referred first to the periods of apnea, the period that had been experienced by the child at home, and then subsequently at the referring hospital?

A. Apnea and bradycardia.

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Q Apnea and bradycardia. Doctor, can we agree, am I correct in my understanding that apnea as well as bradycardia, although when they occur they may be suggestive of Sudden Infant Death Syndrome, can as well be caused from a number of other causes?

A. Yes.

Q Similarly, can bradycardia and tachycardia as a rate disturbance exhibited by an infant, can they be caused as well by diseases or malfunctions other than Sudden Infant Death Syndrome?

A. Yes, I have already told you that sometimes sinus node dysfunction can cause this type of problem.

Q And that would be true as well I take it if the lethargy you have indicated was displayed by Jordan Hines, that could be caused from a number of factors?

A. Lethargy ---

Q That can be caused by other factors?

A. That can be caused by that, sure.

Q Doctor, we have heard evidence as well from Dr. Fowler that it has been suggested in some of the literature that a prolonged QT interval





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on the ECG readings of a particular patient may be indicative of Sudden Infant Death Syndrome. Dr. Fowler testified as well that there appeared to be less importance attached to the prolonged QT interval in current literature than had previously been suggested by other authors. Are you aware, Doctor, as to whether or not a prolonged QT interval was exhibited on any of the ECG readings available with respect to Jordan Hines?

A. He did not have a prolonged QT interval. I think that theory has now been discarded.

Q. I take it you have reviewed the ECG readings and the medical record, and as well in the zebra pack in order to express that conclusion?

A. Yes.

Q. Apart then, Doctor, from the clinical matters particular to Jordan Hines that you have described for us, and as well the issue of a prolonged QT interval, was there anything in the - exhibited by this child in his course in the Hospital, or during his terminal events, with which you are familiar, that in your opinion is suggestive of SIDS, other than the things you have already outlined?

A. Anything else in his clinical history, or in his physical findings? I told you about the infection.





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2 His electrocardiogram, perhaps the  
3 12 leads tracing showed evidence of right ventricular  
4 hypertrophy, showed some STT segment changes on the  
5 right side. You can get this picture in a child who  
6 has had episodes of hypoxia or chronic hypoxia, do  
7 you understand what I mean?

8 Q. Yes.

9 A. And this would be a finding that  
10 you might see in a child with missed-SIDS, who  
11 suffered hypoxia due to irregular control of  
12 respiration, control of cardiovascular function.

13 Q. Other than that, Doctor, was  
14 there anything else that you haven't outlined which  
15 you observed, were made aware of, exhibited by the  
16 child during the course of his life, that in your  
17 opinion was suggestive of SIDS?

18 A. In retrospect I don't know that  
19 I can recall without going to this chart in more  
20 detail. No, probably not. The child's birth weight  
21 was normal. The child's - there is a lot written  
22 about the psycho-social background of the children  
23 with missed-SIDS, there is nothing there really that  
24 I can put my finger on.

25 Q. Doctor, you have indicated that  
the child's birth weight was normal, and we have heard





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in evidence that his birth weight was in fact 8 pounds  
2 ounces.

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A. Yes.

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Q. As I understand it, and perhaps  
you can tell me if this accords with your understanding  
of SIDS, it is unusual to find SIDS with any degree  
of frequency in children with normal birth weights,  
it is much more common in children with low birth  
weights?

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A. Yes. Well, I am sure there must  
have been cases, I know of cases myself who have  
normal birth weight, just my own knowledge. If you  
look at reports they tend to mention it is low birth  
weight infants that tend to have SIDS, but there are  
always exceptions to the rule, Miss Cronk.

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Q. And it does happen?

A. Yes.

Q. Doctor, similarly, at the time

of Jordan Hines' death, we know that he was born on  
February 16th, 1981 and he died March 8th, 1981. He  
was therefore under one month of age at the time that  
he died.

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A. Yes.

Q. I take it that in those circum-  
stances he can appropriately be described as a neonate,









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he was under one month of age at the time of death?

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A. Yes, he was under one month of

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age.

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Q. Doctor, can you help me, in your

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experience is it unusual for SIDS victims to be

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neonates?

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A. I don't think I have done enough  
review of SIDS to give you an answer to this question.

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Q. Leaving aside the case of Jordan

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Hines, Doctor, in your experience at the Hospital

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since you told us 1955, and 25 years of practice, have

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you ever had another patient in whose care you

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participated die in the Hospital in circumstances

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where the death was attributed to Sudden Infant Death  
Syndrome?

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A. I don't offhand recall, certainly

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not in the cardiac wards, it is very unusual for us

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to have a case like that during the time I have served

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on the cardiac ward.

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Q. Thank you. Doctor, one final

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point with respect to the death of Jordan Hines.

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Dr. Rowe testified in evidence before the Commissioner

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that subject to the views of the pharmacologists, the

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forensic findings of digoxin indications with respect

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to Jordan Hines, that subject to the views of the

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pharmacologists concerning those findings, it was his view that digoxin intoxication might have been the cause of this child's death. That evidence, Mr. Commissioner, is found at Volume 18, page 3275 to 3276 and again at Volume 24, page 4309.

Can you tell me, Dr. Rose, is that an opinion with which you agree?

A. I don't think I would use the term intoxication. It is possible that an inadvertent dose might have been given, but I would want to know a lot more about the levels that were found and what they mean.

I think it is very dangerous to present parents of children with this sort of information and confuse them. The Hines were confused and I was very concerned about this. They were not given any information about the pathological findings and what we felt the child had. They were told that the child was allegedly done away with, murdered, and I think that was of great concern to me and it is very unfair to present parents who don't understand what is going on with this sort of information when it is not proven.

Q. Well, Doctor, may I ask you this, you have told us that at the time you received Dr. Bain's report, and at the time the preliminary





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autopsy report was provided to you by the police, you formed the view, or reached the conclusion that the child's cause of death was likely attributable to Sudden Infant Death Syndrome?

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A. Yes.

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Q. That was your view at that time?

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A. Yes.

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Q. Doctor, we know the earliest that those reports could have been provided to you was in the summer of 1982, because Dr. Bain's report was not undertaken until that time?

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A. Yes.

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Q. That is at a time when Susan Nelles had been discharged at the preliminary hearing, and the evidence with respect to digoxin levels in respect of tissues on Jordan Hines' body had been introduced in evidence at that preliminary hearing. At the time that you reviewed Dr. Bain's report of the preliminary autopsy report, were you aware that forensic tests had resulted in findings of digoxin in the tissues from his body?

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A. Yes, I was aware, but I wasn't given any details. I am sure this report must have been available earlier than the summer of 1982, and I think the parents had a right to know what this autopsy report showed.





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Q Well, Doctor, I am not necessarily disagreeing with that, but I am directing your mind however to the state of your knowledge at the time that you reached the conclusion that his death was attributable to Sudden Infant Death Syndrome.

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A Yes.

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Q As I understood you, you did at that time know that digoxin forensic findings had been reached with respect to Jordan Hines, at the time that you reached that conclusion?

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A Yes, that is just something you heard, there was no detail given. In fact, I found out most of this through the media, which I again think is a bad way to find out what goes on in the police investigation.

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Q Doctor, you have told me immediately after the death of Jordan Hines you did not meet with the parents of Jordan Hines, you felt it inappropriate to do so at that stage. Can you tell me whether following his death and following the events of the latter part of March 1981, whether you participated in any meeting with Mr. and Mrs. Hines to review with them the cause of death of their son?

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A No, I did not, because it was not up to me, it was up to Dr. Fowler to have these meetings and he did.









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Q. Thank you, Doctor. The final child, Doctor, that I understand you had any involvement with in terms of the care and treatment of the child in the Hospital was Michelle Manojlovich. We know that she was admitted to the Hospital on February the 2nd, 1981 and that she died on March 12th, 1981.

As I understand it, you in fact were responsible for admitting this child to the Hospital when she first came into the Hospital?

A. That is correct.

Q. And I take it you then followed her course on the cardiology ward?

A. That is correct.

Q. Dr. Rowe has testified, Dr. Rose, with respect to the death of this child, that in his view she must have had a respiratory arrest and in his view it was logical to suppose that the final straw was the probability of aspiration in her case?

A. That is correct, it very often is.

Q. Do you share that view?

A. Yes.

Q. He further testified that while the death of Michelle Manojlovich was sudden, it was not unexpected in his opinion having regard to her course in the Hospital. Do you share that view as well?





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A. Yes, I share that view.

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Q. Did you, Doctor, at the time of Michelle Manojlovich's death, have any concerns as to the direct cause of death?

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A. No, none.

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Q. Sitting here today, Doctor, is there anything you would like to add with respect to this child's death other than your comments with respect to Dr. Rowe's evidence?

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A. I think again we have a child who has been extremely ill all along. She had a very lethal type of heart problem, although we were able to help her somewhat. We had hoped that surgery might assist her to survive. She had two operations. She had a very stormy course after the operations. I had a lot of conversations with her mother trying to prepare her for the death of this child, because I didn't think she had much of a chance but there is always the hope, as I told you earlier, that the child would survive.

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Q. I take it then, Doctor, that you did not find her death in those circumstances surprising?

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A. No.

Q. Doctor, with respect to the





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children who died subsequent to the death of Michelle Manojlovich, as I understand it, you had no direct involvement in the care and management of Kevin Pacsai, is that right?

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A. No.

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Q. Similarly as I understand it, you had no direct involvement in the care and management of Allana Miller, or Justin Cook?

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A. No, I did not.

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Q. Indeed, Doctor, as I understand it, you were absent from the Hospital on holidays for a period in the latter part of March 1981?

A. That is correct.

Q. Can you help me, do you recall now when you were absent from the Hospital?

A. It was the school break, the March break, which I believe was from Friday to Friday, March the 20th was a Friday, to the 28th, I am sorry, I should have checked that out.

THE COMMISSIONER: Friday is the 20th.

THE WITNESS: Yes.

THE COMMISSIONER: This is the only weekend I will be able to tell you the dates. Friday is the 20th, Saturday is the 21st and Sunday is the 22nd.





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MS. CRONK: Q Doctor, prior to departing on holidays, to the best of your recollection and assuming it was March the 20th and for the March break, do you recall any discussion, or did you participate in any discussion amongst members of the Cardiology Division concerning the digoxin level results on Kevin Pacsai and Janice Estrella?

A. I remember hearing about Pacsai, and particularly Mr. Pacsai and the problems he caused, but not particularly about the digoxin level.

Q Do you recall any discussions or did you participate in any discussions prior to departing on holidays with respect to the digoxin levels for Janice Estrella?

A. No.

Q Doctor, finally with respect again to the question of the review process and the preparation of summaries that was undertaken by members of the Cardiology Division in preparation for these hearings. Do you recall we discussed that earlier this morning?

A. Yes.

Q Can you help me, Doctor, Dr. Fowler testified and this evidence, Mr. Commissioner, is found at Volume 34, pages 6742-6743. He testified







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that the six members of the Cardiology group went through every patient at a number of meetings. You have told us this morning that your recollection is there was one meeting for that purpose?

A. Yes.

Q. He indicated further that there were a number of things added and changed from the summaries that had originally been prepared to ensure that there was a consensus of what was thought to be the key problems in respect of each particular patient.

Can you help me, Doctor, do you recall any situation where either you or another member of the Cardiology Division expressed a dissenting view or dissented from what would otherwise be the consensus opinion reached in that group review.

A. The only dissenting view would be as to who was the cardiologist on call that night.

Q. I can understand that.

A. And who was the admitting cardiologist, and this was the most confusing part, because we had to find this out amongst ourselves as to who was actually in charge of the patient at the time. Those were the only - there was no consensus, it was merely a question of providing all





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the information that Dr. Rowe needed in summary form,  
so that he did not have to review the charts.  
Particularly in giving him something about the drug  
dosages and details that he needed.

We all went back to the charts and I  
personally spent hours in the medical records room,  
since those summaries were prepared, because, for the  
purposes of my appearance here and I am sure  
Dr. Fowler did the same, we felt there was a lot of  
additional information we wanted to review for our-  
selves and it might be helpful to this Commission.  
The whole purpose of doing this is to provide this  
Commission with all the information that you might  
wish to have as to our own opinion, each one of us,  
our own opinion about what went on with these children.

Q Doctor, please understand as  
has been expressed before by Mr. Lamek, the method  
that has been described by which that review took  
place is one that, speaking for myself, we are  
comfortable with.

A. Yes.

Q My concern is only to determine  
whether for example in respect of the children in  
whose care you participated, whether any dissenting  
view or contrary view was expressed with respect to  
the cause of death of those children other than what





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has been expressed here today by you, with respect  
to the children that you cared for?

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A. I don't know what you mean by  
dissenting view? Could you explain what you mean by  
that?

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Q. All right. Doctor, in a group  
discussion with respect to discussing the summaries,  
with respect to any particular child, Dr. Fowler has  
told us that one of the purposes was to reach a  
consensus as to what were the particular matters of  
concern, or the key areas of particular importance in  
respect of each child.

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Our concern is only to determine  
whether or not there was any individual opinion  
expressed that was contrary to the general opinion of  
the others expressed as to the cause of death of any  
of these children. Do you recall that occurring in  
respect of any child in whose care you participated?

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A. I think the word "consensus"  
was one I would not have used.

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THE COMMISSIONER: Consensus is a hard  
word. Consensus does not mean unanimity. I think  
what Miss Cronk is after is was there any dissent from  
the view expressed, at least finally put forward, as  
the general view of all of the doctors. Did someone





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at some point, I don't know whether this is, how important it is, did someone at some point say: I don't care what you think I think this child died from "x", you may say he died from "y", but I think he died from "x". Then you go off, and Dr. Rowe says well, most people think he died from "x" so that is what I am going to say. Now that is an example, did that sort of thing happen?

THE WITNESS: Oh no, not at all.

THE COMMISSIONER: Did everyone finally agree on the cause of death of each of the children?

THE WITNESS: I don't think this came up in the preparation of the summaries. The summaries were mainly ---

THE COMMISSIONER: The facts, were they?

THE WITNESS: The facts, that's right.  
The facts for Dr. Rowe.

THE COMMISSIONER: And Dr. Rowe was the one who made his views ---

THE WITNESS: Yes. He reviewed the facts and based on his experience he made his own decision about what he felt was important.

THE COMMISSIONER: Did he express that at these meetings?

THE WITNESS: He might have in some cases.









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THE COMMISSIONER: Was there any disagreement, that's all?

THE WITNESS: There was no disagreement, but it wasn't the consensus, it was, everybody writes down the details of the case, it is just like in any other review process.

THE COMMISSIONER: But it didn't go around the table ---

THE WITNESS: It is like a discussion.

THE COMMISSIONER: It didn't go around the table saying oh, what do you think was the cause of death?

THE WITNESS: No, it was similar to the reviews we have every day, every morning about patients, and we all express our views, and Dr. Rowe needed something to start off with, he was not involved.

MS. CRONK: I am grateful, Mr. Commissioner.

Q. Dr. Rose, one final question. You have told us that in a number of the cases we have discussed, you were either contacted as the cardiologist on call at night at the time of the arrest of the child, and came into the Hospital; or in other situations were contacted and then later





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came into the Hospital after the child had been pronounced dead. I take it therefore, Doctor, that you are familiar with the kinds of resuscitation procedures that are available to be undertaken in the case of an infant experiencing cardiac arrest?

A. Yes.

Q. In your experience, Doctor, on the cardiology wards, is digoxin a drug commonly found on the resuscitation carts of Wards 4A/4B?

A. I really don't know, but I don't think they used it in the resuscitation procedures.

Q. Would you expect to see it, Doctor, on the crash carts?

A. I would not expect to see it.

MS. CRONK: Thank you very much, Doctor. Those are all my questions, Mr. Commissioner.

THE COMMISSIONER: Yes, all right, thank you. Mr. Roland.

EXAMINATION BY MR. ROLAND:

Q. Dr. Rose, carrying on from the questions you were asked about the meetings that you had with the other cardiologists in preparing the summaries. Do I understand it from your last comments that this meeting in substance was really no different than the kind of meetings that you have on a regular





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basis with the other cardiologists, to discuss not only the treatment of patients and the illnesses that you are treating, but also the deaths of patients as they occur?

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A. Yes.

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Q. And that doctors and cardiologists in The Sick Children's Hospital regularly meet in both formal and informal basis to discuss the events of both of the treatment and the illness of the patients, and the death of the patients?

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A. That is correct.

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Q. And to put it directly, I take it you are saying that there was no agreement among the cardiologists to present any sort of a united front about the facts of the cases, or the conclusions reached?

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A. Absolutely not, no agreement. This was simply a discussion, a review of each case to simplify the reporting.

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Q. One other matter that was not raised in Miss Cronk's examination, and that is the matter of clustering. You have been a cardiologist in this Hospital for many years?

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A. Yes.

Q. In the course of your experiences





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as a cardiologist, have you noticed the phenomena  
that we have heard of called clustering?

A. Very much so, yes.

Q. Is that something that you have  
noticed both before the period that is under inquiry  
here and since that time?

A. Yes.

Q. Can you tell us what clustering  
is?

A. Clustering is just an unusual  
occurrence of larger numbers of patients with either  
any type of cardiac defect, or specific type of  
cardiac defects in a certain period of time, we see  
this all the time.

I looked into this some years ago  
just by going through our data system to see if I could  
relate a cluster to a particular event that might  
have occurred early in the pregnancy that might have  
been the cause of this defect occurring at this  
particular time. This would be very helpful in  
forming an idea as to what the cause of congenital  
heart disease is.

I would regard the numbers in the  
summer of 1980 as a cluster, always regard it as a  
cluster. We have had a cluster since, in 1982 when







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2 we had a meeting which was attended by senior staff  
3 in the Hospital and the coroners about the clustering  
4 in August, 1982, I believe of the children who died,  
5 because by that time they were dying in Intensive  
6 Care mainly and not on the cardiac ward.

7 I personally expect we are going to  
8 see another cluster, because now we are getting  
9 patients from Edmonton and Calgary where the cardio-  
10 vascular surgeon present is absent or has retired  
11 and they haven't appointed a new one yet. I hope  
12 we won't see deaths, but we are going to see very  
13 sick children coming in for surgery, for care, from  
14 that area. So it wouldn't surprise me if we have  
15 another cluster in the next year.

16 Q. Let us deal with the period of  
17 July and August of 1980.

18 THE COMMISSIONER: Can I just  
19 interrupt for a moment. I don't quite understand  
20 about Edmonton and Calgary? They presumably would  
21 have - it would simply mean you would have more  
22 patients.

23 THE WITNESS: More patients, yes,  
24 this is what I mean by clustering.

25 THE COMMISSIONER: Well, I wouldn't  
have thought that was a cluster, I would have thought,





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are you not suggesting you would have a greater  
percentage of the patients die?

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THE WITNESS: No, I am not talking  
about death I mean, I am talking about numbers  
presenting with congenital heart disease.

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THE COMMISSIONER: It is not really  
a cluster, it is a greater number of patients coming  
in. What we are concerned about in this Inuquiry is  
the cluster of deaths on the ward during this period.

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THE WITNESS: Yes.

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THE COMMISSIONER: Have you encountered  
something like that with - and we are concerned with  
the greater percentage of the number of children  
that are there.

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THE WITNESS: Yes.

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THE COMMISSIONER: We haven't had an  
accurate figure of the number of children that were  
there at the time. If you get more children in from  
Calgary and Edmonton you are bound to have more  
children with certain defects, and with more children  
you are bound to have more children die.

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THE WITNESS: That's right.

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THE COMMISSIONER: That I can under-  
stand, but that I would not have thought was a real  
cluster.

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THE COMMISSIONER: Well, if you have more - you see, if you have more of anything, if you have more cars on the highways you're going to have more accidents but I wouldn't call that a cluster of accidents. I would have thought it is if you have on one day, Monday, the same number of cars on the highway as you have on Tuesday, but on Monday for some reason you have twice the number of accidents then I might call that a cluster.

But you are talking about coming in from Calgary and Edmonton and I don't quite see what the connection is between that. In August of 1982, the diagram which is an exhibit over there, and I don't know what exhibit it is, but in August of 1982 is that the total deaths in the Hospital?

THE WITNESS: Well, they show there also the total deaths.

THE COMMISSIONER: But there was no cluster in the wards in that period at all, was there? There was no cluster, the line for the wards you see is that blue/green line at the bottom.

THE WITNESS: Yes.

THE COMMISSIONER: That is Ward 4A and 4B.

THE WITNESS: Right.





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2  
3 THE COMMISSIONER: And there is no  
4 cluster of deaths anywhere except in the period that  
5 has sometimes been called the epidemic period. There  
6 may be an increased number of deaths in the Hospital  
7 generally but that may be related to all kinds of  
8 other factors that we know nothing about.

9 THE WITNESS: The reason that you  
10 have the peak which, the yellow peak I believe is  
11 the Intensive Care Unit, am I correct?

12 THE COMMISSIONER: It might be.

13 MS. CRONK: Yes, it is ICU.

14 THE WITNESS: Yes. Is that the  
15 sick babies, the cardiac babies at that time were  
16 more readily accepted by the intensivists and there-  
17 fore the cluster there is the peak is in the  
18 Intensive Care versus the Cardiac Unit.

19 What I'm really saying is that I  
20 don't know what these children will be like but they  
21 may be very sick babies. You know, I am just  
22 concerned that when you have sick babies of course,  
23 as I said before, we try and do what we can but we  
24 may not always be successful and we may come up with  
25 a peak period. I mean, I shouldn't really be talking  
about this because that doesn't apply to the period  
that this Commission is looking into. What I mean









1  
2 is that it is possible to have clusters of children  
3 with critical heart disease coming in at particular  
4 times. I have encountered this, although, I am not  
5 an epidemiologist and I don't look at it as an  
6 epidemic, I look at it as a cardiologist, as a  
7 clinician.

8 We mentioned this from time to time  
9 that, haven't we had a few of these just recently,  
10 you know.

11 MR. ROLAND: Q. Dr. Rose, I take  
12 it that the babies that are coming from Edmonton  
13 and Calgary are the particularly sick babies?

14 A. Yes.

15 Q. They wouldn't come this  
16 distance if they weren't very sick?

17 A. Absolutely.

18 Q. So, it is really the worst  
19 cases from Alberta that you see at the Hospital for  
20 Sick Kids when there is not a cardiologist available.

21 A. A cardiovascular surgeon.

22 Q. A cardiovascular surgeon  
23 available?

24 A. Right.

25 Q. So, when you talk about a  
cluster in that context I take it what you are seeing





1  
2 is a phenomenon where you are experiencing at the  
3 Sick Kids Hospital a concentration of very sick  
4 babies?

5 A. That's right.

6 Q. What I really want to express  
7 to this Commission is that whereas the epidemiologists  
8 coming in from outside and looking at our figures  
9 will say from an epidemiology point of view, you  
10 have had an epidemic, what they don't understand is  
11 that we have had patients, for instance, in 1980  
12 coming from Winnipeg. That it is not simple that we  
13 are looking at something that happens at Sick  
14 Children, there are other circumstances that will  
15 explain why we have more sick babies.

16 THE COMMISSIONER: Oh, yes.

17 MR. ROLAND: Q. And, Dr. Rose, we  
18 have heard from both Dr. Rowe and Dr. Freedom that  
19 their impression in the summer of 1980 and  
20 particularly July and August of 1980 that you were  
21 experiencing in the cardiac ward a concentration of  
22 very young and sick babies, more so than you had  
23 experienced on previous occasions?

24 A. Yes.

25 Q. Was that your impression at  
that time as well?





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A. It was my impression at that time and we were all concerned about it. This is why we took steps to see what we could do.

Q. Right.

THE COMMISSIONER: Whatever you like.

MR. ROLAND: Yes, I am going to move on to another topic.

THE COMMISSIONER: Yes, all right.  
Well, I think we will rise now until 2:30 then.  
---Luncheon recess.

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AA/BB/ak

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---Upon resuming at 2:30 p.m.

3

THE COMMISSIONER: Yes, Mr. Roland.

4

MR. ROLAND: Yes.

5

Q. Dr. Rose, Dr. Rowe was asked

6

about various ways in which babies' hearts may stop

7

and he has been good enough to provide us with 14

8

different causes of death that may result in the

9

stopping of babies' hearts. The chart is there to

10

your right indicating those 14 different ways.

11

THE COMMISSIONER: I wonder, I

12

think that exhibit number is now written on it, isn't it?

13

MS. CRONK: It is 160,

14

Mr. Commissioner.

15

MR. ROLAND: Yes, 160.

16

THE COMMISSIONER: 160.

17

MR. ROLAND: Q. Those are, in

18

summary: heart failure, hypoxia, sepsis, respiratory

19

illness, instability of temperature, low birth weight,

20

four kinds of conduction failure, types of conduction

21

failure, acidosis, apnea, anemia and Di George

22

Syndrome. Do you recognize those as 14 different ways in which, or causes for a baby's heart stopping?

23

A. Yes.

24

Q. Dr. Rowe went on to indicate

25







1  
2 that the various symptoms of digoxin toxicity such  
3 as bradycardia and vomiting and the sudden onset of  
4 death accompanied by ventricular fibrillation and  
5 arrhythmia may also be evident in those 14 causes of  
6 death, other causes of death to varying degrees. Do  
7 you agree with that?

8 A. Yes, I think that is correct.

9 Q. Yes. Thank you, Dr. Rose,  
10 those are all the questions I have.

11 THE COMMISSIONER: Mr. Ortved?

12 MR. ORTVED: I have no questions,  
13 thank you, Mr. Commissioner.

14 THE COMMISSIONER: Yes, thank you.  
15 Mr. Brown?

16 MR. BROWN: I have no questions,  
17 Mr. Commissioner.

18 THE COMMISSIONER: Mr. Strathy?

19 MR. STRATHY: Yes.

20 CROSS-EXAMINATION BY MR. STRATHY:

21 Q. Doctor, you mentioned that  
22 your responsibilities include the keeping of  
23 statistics in cardiology, am I right on that?

24 A. No, I don't think it is  
25 statistics that I keep, but I am in charge of the  
cardiology record system, or I was for many years.





1  
2 So, my responsibility was that the records are duly  
3 completed so that they could be accurately recorded  
4 into the computer file. From this file a number of  
5 people working in the division would work out  
6 statistics when they did specific studies.

7 Q. So, there is I take it some  
8 form of what you might call a data bank in cardiology?

9 A. That's correct, the data base,  
10 data bank, that's correct.

11 Q. And that's something that's  
12 been maintained by the Cardiology Department for some  
13 years?

14 A. For some years. In fact, it  
15 forms the basis of Dr. Keith, Rowe and Vlad's textbook  
16 of Pediatric Cardiology.

17 Q. This is the book at which  
18 Dr. Rowe is one of the editors.

19 A. That's right, yes.

20 Q. The big green book?

21 A. That's right.

22 Q. So, some of these statistical  
23 information that you accumulated over the years,  
24 some of the data base went into the making up of that  
25 text book?

A. Yes; that is correct.





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Q. In answer to a question by Mr. Roland you indicated that using that data base, as I understood it, you had done some of your own research with respect to clustering?

A. That's right.

Q. When was that, Doctor?

A. It was a good number of years ago, I don't have the exact time, I think it was in the early seventies.

Q. And have you had occasion to do other work with respect to clustering?

A. No.

Q. Speaking however as a pediatric cardiologist and taking into consideration the work which you have done in that area, I take it your evidence is clearly to the effect that clustering is a phenomenon that occurs in children with heart disease?

A. Yes.

Q. May I be certain as to what I understand is clustering. Is that groupings of children about a particular form of disease?

A. Yes.

Q. Or is it groupings of children with a particular serious disease or is it both?





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A. It could be both, occurring at certain times of the year on a certain space of time. This is just an observation we have.

Q. So, in your observations you may have children with a particular disease, let us say patent ductus arteriosus?

A. Yes, that's right.

Q. Occurring at a particular time during the year?

A. That's right.

Q. You may also have, by your own observations, particularly sick children with congenital heart disease occurring in groups throughout the year?

A. That's correct.

Q. So, if you see a grouping of particularly sick children at any point in your Hospital, to be specific.

A. Yes.

Q. You might call that a clustering?

A. Yes.

Q. And it is not something that would particularly surprise you in your experience?

A. This is what happens and it







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surprises us at the time and we look for reasons why  
it might have occurred but we usually don't get an  
answer very clearly.

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Q. So then you say you look for  
reasons. Do I take it that there may not be totally  
sensible or comprehensible explanations for these  
clusters when they occur?

9

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A. That's correct.

Q. Would it be fair to say that

in the area of pediatric cardiology there are  
clusters that happened or happen that may not be  
fully explained?

13

A. That's correct, yes.

14

15

16

Q. There may be reasons for them  
but you just don't know what those reasons are given  
the state of the art?

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22

A. Yes.

Q. Well now, dealing with this

period, or at least part of the period that we are  
talking about, the summer of 1980, and let us say  
July, August, September of 1980. As I understood  
your evidence you saw, simply looking at the chart,  
Exhibit 125, you see a clustering in that period?

23

24

25

A. That's correct, yes.

Q. We have heard in fact that





1  
2 there were a number of deaths on Wards 4A and 4B  
3 during that period?

4 A. Yes.

5 Q. We have heard evidence, I  
6 take it you agree with the evidence that during that  
7 time doctors perceived that there were particularly  
8 young and particularly sick children on those wards  
9 at that time?

10 A. That's correct, yes.

11 Q. And given that the children  
12 were particularly young and particularly sick, would  
13 that explain why there are such an increased number  
14 of deaths during that period?

15 A. This is what we felt was the  
16 reason for this.

17 Q. Do you know why, in other  
18 words, what is the reason for that clustering at  
19 that time of particularly young, particularly sick  
20 children?

21 A. I don't know that we knew  
22 precisely. I think there was only one child from  
23 Winnipeg in that group. I think there were others  
24 in Intensive Care but I know we were receiving sick  
25 babies from elsewhere. I am not sure when the  
helicopter service was instituted. I think since





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the helicopter has been available we have received sicker babies, you know, we have been able to salvage babies even though they remain quite sick.

Q. All right. Are there any other explanations that come to mind for that clustering at that time, apart from the ones that you have mentioned?

A. The only other thing that happened in 1980 was that we moved to 4A/B from 5A. 'So, there was a different volume I think, although, I don't recall the exact numbers in a sort of a reorganization of the cardiology ward.

Q. I'm sorry, a different volume of patients coming in?

A. I'm not sure if it is volume but we tended to concentrate our patients on that ward because of the expertise in nursing and so on, whereas, prior to that, we had patients spread around the Hospital. They might be on other infant wards rather than on cardiology.

Q. Well, would you agree then, Doctor, that whatever may have been the reasons for that clustering?

A. Yes.

Q. You yourself do not see





1  
2 anything sinister in the fact that there were an  
3 unusual number of deaths during that period?

4 A. Not sinister, no.

5 Q. You see it as being explained  
6 by the very conditions of the children that you  
7 were treating?

8 A. Yes. This is what we looked  
9 into and this is the conclusion we came to at the  
10 time.

11 Q. And may I take it at the  
12 present time as well with respect to that period  
13 you yourself are satisfied again that it is based  
14 on the condition of the children themselves?

15 A. Yes. On looking at all  
16 these children and the type of problems they had,  
17 which Dr. Rowe has demonstrated and which we have  
18 reviewed many times over ourselves again and again  
19 we felt that these children were indeed very sick  
20 and it so happened they all seemed to happen at  
21 that time and this is how we viewed it.

22 Q. Thank you. Now, you were  
23 telling Mr. Roland and I'm afraid I just didn't  
24 catch it about a clustering in August, 1982.

25 A. Was it August, 1982?

Q. Well, I don't think in fairness







1  
2 to you this graph doesn't go up as far as August,  
3 1982, so, we may not see the clustering.

4 A. Was it '82 or '81? I believe  
5 it might have been '81.

6 Q. Well, yes, in '81, it looks  
7 like around the end of the year.

8 A. I think that's the one I meant.

9 Q. There was a big peak on this  
10 yellow line.

11 A. Is that around August?

12 Q. Well, frankly I can't tell  
13 whether we have January - it looks as though it is  
14 November, Doctor, of 1981.

15 A. I remember meeting in August,  
16 I'm not sure if it was '81 or '82, which we reviewed  
17 it a number of deaths that the chief of pathology  
18 had been concerned about. That was certainly an  
19 increased number of patients during that particular  
20 month.

21 Q. Well, do I understand that  
22 whenever it was it was an increased number of deaths  
23 in the ICU?

24 A. Increased number of deaths of  
25 children with severe congenital heart disease. At  
that time they were being transferred off the cardiac





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ward and they did not occur necessarily on the cardiac ward it occurred elsewhere but they were children with severe congenital heart disease.

Q. So, it wasn't just ICU patients generally?

A. No.

Q. It was heart ICU?

A. No, it was heart, yes. It was children with congenital heart disease severe enough to cause death in that particular period.

Q. And it was perceived I take it to be a fairly dramatic number of deaths in the ICU?

A. It was a cluster that we were looking at at that time.

Q. Well, I use the word dramatic because I gather the coroner was brought in at that time?

A. Well, we felt it was appropriate to call the coroner in as well to see, to go over the patients with us.

Q. All right. Now, did you come up with an explanation as to that cluster in the ICU of congenital heart defects or death related to that?

A. We reviewed each case as we





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are doing now, reviewed the clinical surgery, autopsy finding and found that these were just particularly sick babies, many of them critically ill who did not survive. We also looked at their digoxin levels.

Q. Now, just lastly on the subject of clustering, you mentioned this business that you expected perhaps a further clustering to take place because you had babies coming in from Edmonton and Calgary?

A. Yes.

Q. And I gather really all you are saying is that you may have an influx of particularly sick babies coming in from those areas?

A. Yes.

Q. Because their own surgeons are not available?

A. That's right. They don't at the present time have a surgeon. I'm just trying to make the point that you can have a cluster of sick babies for reasons other than sinister reasons.

Q. Yes, that's fair enough. What you are saying I take it is that although you certainly hope your death rate doesn't go up as a result of this?

A. Yes, exactly.





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Q. It may go up as a result?

3

A. Yes. I would sincerely hope

4

that it won't.

5

Q. Of course not.

6

A. Right.

7

Q. But it is something that can

8

happen just because you are getting more sick babies?

9

A. That's correct.

10

Q. Thank you.

11

THE COMMISSIONER: What I thought

12

the point was that you get these clusters without

13

any reason. Wasn't that the proposition that was

14

being put forward here, or am I wrong?

15

THE WITNESS: Yes.

16

THE COMMISSIONER: I am wrong.

17

THE WITNESS: There may be an

18

explanation for cluster that you could find based

19

on what ---

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THE COMMISSIONER: Well, there may

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be a sinister explanation for a cluster and there

22

may be an innocent explanation.

23

THE WITNESS: That's right.

24

THE COMMISSIONER: But I thought

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that the proposition that you were making was that  
they can happen without explanations at all.







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THE WITNESS: As well, that's right,  
sometimes we don't have an explanation.

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MR. STRATHY: Well, may I just,  
Mr. Commissioner ---

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THE COMMISSIONER: Yes, certainly.

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8

MR. STRATHY: Q. I suppose the  
proposition that I put to you, Doctor, is that you  
may not know the explanation.

9

A. Yes.

10

11

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Q. The state of your art is  
not sufficiently developed for you to be able to  
say that's the explanation for this cluster?

13

A. That's right.

14

15

Q. Another possibility is, they  
may just simply happen at random?

16

A. That's possible.

17

Q. So, there may be no explana-  
tion for them in that sense?

18

19

A. Yes. We always try and find  
an explanation if we can.

20

Q. Yes, of course.

21

THE COMMISSIONER: Yes, all right.

22

MR. STRATHY: I don't know if I have  
satisfied you or not?

23

24

25





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2  
3 THE COMMISSIONER: Well, you haven't  
4 solved my problem but at least I know what the  
5 evidence is.

6 MR. STRATHY: Q. Doctor, I take it  
7 we have talked about your preparation for these  
8 hearings and the ordeal that you doctors have been  
9 through in spending your time other than on the  
10 wards looking after babies and actually worrying  
11 about legal matters. Have you spent some time, I  
12 take it you have, with Ms. Cronk and Mr. Lamek in  
13 preparation for these hearings?

14 A. With Ms. Cronk.

15 Q. With Ms. Cronk. Do you know  
16 how much time you have spent?

17 A. I think it was a couple of  
18 hours maybe.

19 Q. And this subject of clustering,  
20 did you discuss that with Ms. Cronk?

21 A. Did we, I'm not sure?

22 Q. Well, I don't think you should  
23 ask her, you tell me if you recall it.

24 THE COMMISSIONER: Well, we don't  
25 want to force Ms. Cronk to enter the witness box.

MR. STRATHY: I would be quite  
happy to put her there but she has been doing a





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good enough job giving evidence already.

3

THE WITNESS: I think we mentioned

4

it, yes.

5

MR. STRATHY: Q. You think it was

6

raised?

7

A. I think it was raised.

8

Q. All right, thank you.

9

Doctor, let me turn to another area. I wanted to  
ask you about the subject of autopsies. I was

10

interested to hear that in the case of, I think it  
was Baby Hines and Baby Colleen Warner?

11

12

A. Yes.

13

Q. You actually went to the

14

Pathology Department and at least observed a part  
of the autopsy yourself?

15

A. That's correct, yes.

16

Q. And you actually observed the

17

hearts of both those babies?

18

A. Yes.

19

Q. Is that something you do from

20

time to time when you have a question about a child's  
death?

21

A. Yes.

22

Q. And do you find that helpful,

23

I take it you do, to actually go and see the anatomy

24

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AA16





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of the child after the fact?

3

A. Yes.

4

Q. Very often it assists you

5

understanding why the child died, when it did?

6

A. That's right. In addition

7

to that we have our pathology reviews and meetings

8

with Dr. Freedom and Dr. Wilson on a weekly basis.

9

Q. Yes. As I understood it,

10

Dr. Freedom provides the pathology input to your  
daily discussions?

11

A. That's right.

12

Q. And also there is a weekly

13

discussion?

14

A. That's correct.

15

Q. But obviously for your own

16

purposes actually being there looking at the child's

17

heart is of considerable assistance to you?

18

A. Yes. If I am personally

19

involved I often go and do that.

20

Q. If you are personally involved

21

with the child?

22

A. Yes.

23

Q. Now, as I understand it, and

24

we have heard evidence on this, if a physician wants

25

to have an autopsy performed on a particular child







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the first step is to ask the parents?

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A. Yes.

4

Q. If you have the parents'

5

permission there is no problem, you get an autopsy,

6

is that so?

7

A. Yes.

8

Q. And if there is a question -

9

if the parents object the only way to have an autopsy

10

is actually to go to the coroner and to request an

11

autopsy?

A. Yes, but we wouldn't do that

12

routinely in any case, we would only request the

13

coroner's autopsy if there was a reason or some

14

concern about this patient.

15

Q. Well, that's what I was going

16

to ask you. Would I not be right in understanding

17

that in a given case if the parents objected to an

18

autopsy but you yourself felt an autopsy was necessary  
because you had concerns about the death?

19

A. Then I would call the coroner.

20

Q. Would you not consider it

21

your obligation to go to the coroner and say, I'm

22

not satisfied I want an autopsy?

23

A. Yes.

24

Q. And would you do that as a

25





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matter of course if you were worried about the  
reasons for the child's death?

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A. Yes.

5

Q. So, may I take it that in  
those cases that we've seen, and there have been a  
few of them, you have mentioned two, Lombardo and  
Bilodeau?

6

7

8

A. Yes.

9

Q. Where there were no autopsies?

10

A. Right.

11

Q. May we take it that the reason  
was that the physicians treating the children,  
including yourself, were sufficiently satisfied at  
the time that the child's death was explained by  
the anatomy or the clinical course in the Hospital?

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A. That's correct.

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Q. Now, doctor, I am probably going to get in trouble in this area, but I am going to ask you anyway and see if I get in trouble.

One of the observations that you made in the course of your evidence in chief when you were being asked questions by Miss Cronk - one of your answers to Miss Cronk was that we have a lot to learn about digoxin. That is the note I have of your answer.

I want to ask you, doctor, as a cardiologist treating children, can you tell us in what areas you feel we have a lot to learn about digoxin?

A. I think I meant by that we have a lot to learn about digoxin levels in tissues, particularly post mortem specimens.

Q. Was there anything else you meant or was that what you were directing your mind to?

A. That is what I mainly directed my mind to.

Q. May I ask, doctor, before March of 1981 as a pediatric cardiologist did you even cast your mind to that issue of post mortem





BB2

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digoxin tissue levels?

3

A. Not at all.

4

Q. Not at all?

5

A. Not at all, no.

6

MR. STRATHY: Thank you very much.

7

THE COMMISSIONER: Thank you,  
Mr. Strathy.

8

Mr. Hunt.

9

CROSS-EXAMINATION BY MR. HUNT:

10

Q. Now, Dr. Rose, Baby Hines

11

in Dr. Rowe's view died at a time when, according  
to him, no one expected the baby to die overnight.

12

Do you agree with that?

13

A. Yes, I think any death,

14

you know, occurs at a time when you don't expect

15

it. I don't think anyone expects a death to occur

16

at that particular time.

17

THE COMMISSIONER: Well, I don't  
think it is as simple as that.

18

MR. HUNT: I don't think so.

19

THE WITNESS: Maybe I didn't

20

understand your question.

21

THE COMMISSIONER: We do expect

22

dying persons to die and we expect them to die with-

23

in a reasonable time. We don't expect people who

24

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BB32

1  
2 are stable at this moment suddenly to up and die,  
3 that is all. It may happen. It may happen  
4 legitimately without any sinister motives. But  
5 surely, if someone whose breaths are getting  
6 heavier and heavier and he is as old as I am or  
7 older, you would not expect him to live long, would  
8 you?

9 THE WITNESS: I think it is a little  
10 different in young children and older people.

11 I think I want to make a point  
12 about this note of "stable" which often appears on  
13 the chart. Stable doesn't mean better. Stable  
14 means there is no change. The child may be quite  
15 sick, in failure, be under treatment for this  
16 particular problem and then may tip for some reason  
17 or other and die.

18 THE COMMISSIONER: Yes. Well, I  
19 don't want to get into an argument with you,  
20 doctor, I am bound to lose if I do on a medical  
21 point --

22 THE WITNESS: Well, I think it is  
23 important to make that point.

24 THE COMMISSIONER: I just want to  
25 straighten out the question.

THE WITNESS: Yes.





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THE COMMISSIONER: The question was that Baby Hines was not expected to die that night. Now, you don't have to say yes to that or no to that if you don't want to, but that was the question.

Isn't that what you asked?

MR. HUNT: Yes.

THE COMMISSIONER: Isn't that a fair question?

THE WITNESS: No, that is a fair question.

THE COMMISSIONER: And the answer is he was not?

THE WITNESS: Not.

THE COMMISSIONER: Yes. All right.

MR. HUNT: Q. He wasn't expected to die. All right.

Dr. Rowe also agreed with Mr. Lamek that the arrest, the terminal events of Baby Hines were sudden, described as a sudden arrest. Would you agree with that?

A. Again, you have a problem there.

The child develops a rhythm disturbance. All right. That wasn't sudden. I





BB5

1  
2 suppose the occurrence of dysrhythmia was sudden  
3 because he was in sinus rhythm one minute and the  
4 next minute he was in a regular rhythm. But at  
5 that time he had not died. He was manifesting a  
6 rhythm disturbance which led eventually to his  
7 demise.

8 Q. Well, Dr. Rowe was, I  
9 don't think -- he was dealing with the terminal  
10 events as such from the beginning to end and  
11 described them as a package, I suppose, as being  
12 rather sudden.

13 Are you taking issue with that?  
14 I don't understand exactly what you are saying.

15 A. It depends what you mean  
16 by "sudden". I think this is an electrical mode  
17 of death as it is for all children, and if it  
18 occurs from one minute to the next you might call  
19 it sudden or you might call it gradual.

20 Q. So are you disagreeing  
21 with Dr. Rowe?

22 A. I'm not really disagreeing.  
23 I am just putting it a little differently.

24 Q. All right. In any event  
25 he also indicated that at the time of death and  
in discussion at the morning conference the next





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day that they, and I take it that was referring to the cardiologists discussing it, really weren't sure as to the cause of death.

A. No.

Q. Does that accord with your recollection?

A. Yes.

Q. He went on to point out that you were adamant; you felt it was critical that there would be some further enquiry into the cause of death, that you wanted a post mortem examination.

A. Yes. I thought it was very important to get a post mortem examination in this case.

Q. And you were so adamant about that, I think he indicated you expressed the view if the parents would not consent to a post mortem examination that you were prepared to go to the Coroner.

A. I didn't actually voice this because the parents had already consented. There wasn't any difficulty in getting their consent for autopsy examination. That occurred during the early hours of the morning after the







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child died, so really there wasn't any discussion at our meeting about calling the Coroner because the consent had already been obtained and I knew we would get some answers.

Q. Do you know how he would have the impression that you had indicated that if you couldn't get an autopsy that it should be reported to the Coroner?

A. I think he thought this would have been the way I would have acted, he is correct in that.

Q. All right.

So that in any event it was the sort of thing that had the parents not consented to the post mortem examination you would have taken extra steps yourself to see that this investigation was carried out?

A. Yes.

Q. Now do I take it from that that in respect of Baby Hines as of the time of death and the next day, quite clearly in your mind there was a need for further investigation into this?

A. There was a need for an autopsy.





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Q. What was the purpose of that?

A. The autopsy?

Q. If not for further investigation into the cause of death?

A. Well, I don't know what you mean. You meant the autopsy or other investigations?

Q. Well, let's refer to the autopsy.

A. Yes, there was a need for an autopsy, a detailed autopsy in this case.

Q. Further enquiry into the cause of death?

A. Yes. I even asked for -- I asked the residents to be sure that samples would be sent for virological studies, and that was what was going through my mind at the time.

Q. Now given that background to the situation you have indicated, it never crossed your mind to call the Coroner with respect to Baby Hines?

A. Well, it was perfectly well known that our pathologists who are very expert in doing autopsies in babies are called upon





Rose  
cr.ex. (Hunt)

BB9

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by the Coroner to perform those autopsies and I

3

knew that --

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Q. All of them?

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A. Someone like Dr. Becker,

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if it had been a Coroner's autopsy, would have just  
put on his other hat and done the same autopsy.

7

Q. Is it your impression

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that all of the pathologists are --

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A. It is my impression that --

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Q. -- required or requested

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from time to time by the Coroner or only some of  
them?

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A. I think if there is an

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infant, certainly our infant cardiac deaths that

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are Coroner's cases, in those cases the autopsy

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is usually performed at Sick Children by one of

16

our pathologists.

17

Q. My question was is it

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your impression that all of the pathologists

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are able to perform autopsies at the request of

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the Coroner --

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A. No, I think --

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Q. -- or just some of them?

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A. I think some of them.

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Q. All right.

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Now you indicated this morning that in respect of Baby Hines, and I am going to suggest to you what I took from your evidence, and if I have taken something incorrectly, I want you to set me straight on it.

I took from what you said that your inability to get information about Baby Hines had something to do with the police coming in during the third week or the weekend of the 22nd/23rd of March, and as a result of that you were left in the dark virtually with respect to that.

Is that fair or did I misintepret what you said?

A. That is correct. That is what I --

Q. And it may have been subtle but you were feeling some criticism there I take it over the fact that you were unable to get this information?

A. Yes. It is really frustration more than anything else.

Q. Right.

Well, Baby Hines died on the 8th of March and the autopsy was done five hours later on the 8th of March.







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What did you do between then  
and the time the police came in on the weekend of  
the 21st/22nd in order to get information yourself  
about the death of Baby Hines?

A. I spoke to the pathologist.  
The one I addressed was the one who usually works  
with us, Dr. Wilson, I think. I am not sure if it  
was him or one of the others, and I asked have you  
done the microscopy yet, and I was told, no, we  
haven't, we haven't completed our microscopic  
examination yet and we are very anxious to find  
out what that showed.

I was told don't ask us; it will  
take three or four weeks, and I knew that from  
other experience that it does take time and there  
is no point in asking. It takes time to get the  
results.

Q. It takes time, three or  
four weeks, so I take it you didn't do anything  
after that?

A. Well, I couldn't. There  
was no way, because after that the police investi-  
gation began and there was no way I could get near  
the chart or get any information at all.

Q. Well, did anybody stop you





BB12

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from talking to Dr. Becker?

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A. I am not sure if Dr.

4

Becker was able to give me any information. I  
thought that we could get no information.

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Q. Did you ask him?

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A. I did not ask him, no.

7

MR. HUNT: Do you have Exhibit

8

103 there, Mr. Registrar?

9

Q. Do you have it there,

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Dr. Rose?

11

A. Yes.

12

Q. It is the final autopsy

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report which I think it was indicated by Miss

14

Cronk that this may appear to be simply a copy of

15

the preliminary autopsy report but with the word  
"final" at the top of the first page.

16

If you look over on page 2 you

17

will see Dr. Becker's signature down at the bottom.

18

A. Yes.

19

Q. On the right-hand side.

20

And over on the left-hand side in writing below

21

the initials "E.L.B.", do you see the date "25-3"  
of '81?

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A. Yes.

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Q. Now, we haven't had

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evidence with respect to that yet, but if that report was prepared on the 25th of March of 1981, surely there was nothing to prevent you from becoming aware of the substance of this as of that time?

A. No. I was told that we could get no information on any of the patients that were under investigation; that it was in the hands of the Coroner and the charts would not be available to us. We could get no information and so I did not pursue it any further at that point.

Q. You do not know personally whether Dr. Becker had a copy of this notwithstanding what the police may have had?

A. I am sure he must have known, but maybe he thought he could not pass on the information until he got the authority.

Q. He may have felt that, but you didn't ask him whether he felt that or not?

A. No, I didn't pursue it after I was told there was no way we could access information.

Q. All right. You didn't pursue it after sometime I suppose around the second or third week in March?





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A. That's right. I was  
away I think the third week in March.

Q. All right.  
You didn't pursue it prior to the  
police coming in and you didn't pursue it in terms  
of speaking with Dr. Becker for some time after that.

I suppose you got -- you saw a  
copy of this report from the police some time  
later?

A. Yes.  
Q. Up to that point in time  
had you spoken to Dr. Becker about it?

A. No.  
Q. Would you agree with me  
if you had spoken with Dr. Becker presumably you  
would have had access to whatever information he  
had?

A. Possibly. I am not sure  
if this is a case under investigation that he would  
have been able to tell me, but I don't know; I  
didn't ask him.

Q. Had you ever encountered  
secrecy with pathologists before in cases under  
investigation?

A. I think if it is a case







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under investigation I usually cannot get any  
information until the Coroner has approved it.

Q. I see.

Now I have heard, and I'm going  
to ask you to confirm this for me, that there is  
a conference on digoxin that is being sponsored  
by The Hospital for Sick Children?

A. Yes.

Q. In November of this year?

A. I believe so.

Q. And when was that  
arranged, do you know?

A. I don't know.

Q. And am I right that the  
nature of that is to invite people, qualified  
people from Canada and elsewhere to come and speak  
on the subject of digoxin at a conference to be  
held here in Toronto?

A. I believe so.

Q. Do you know whose decision  
it was to hold the conference?

A. I don't know.

Q. You don't know whose  
decision it was to hold it at that particular time?

A. I don't know.





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Q. But you are aware that  
it is going to be held?

A. Yes.

MR. HUNT: Thank you. Those are  
my questions.

MR. ROLAND: I am not sure what  
the purpose of that question is. Maybe Mr. Hunt  
wants an invitation.

THE COMMISSIONER: Well, I am just  
thinking that --

MR. ROLAND: I am not sure that  
he is entitled to go.

THE COMMISSIONER: I am not too  
sure of the time --

MR. PERCIVAL: Mr. Commissioner,  
they wanted you to chair it.

MR. HUNT: Perhaps it will issue  
its report at the same time as yours, sir.

THE COMMISSIONER: Well, it is  
very interesting. I have made a note of it anyway,  
I can assure you of that. I don't intend to go  
but I might send a spy.

MR. STRATHY: How about a subpoena?

THE COMMISSIONER: All right.

Mr. Percival.





BB17

CROSS-EXAMINATION BY MR. PERCIVAL:

Q. Doctor, I understand that you gave evidence this morning to the effect that you felt that Mr. and Mrs. Hines were misinformed with respect to certain events surrounding the death of their child?

A. No, I did not feel that they were misinformed, but I felt that they were informed about the death of their child -- well, the fact that I heard it through the media rather than any other way.

Q. When was the last time you talked yourself to Mr. and Mrs. Hines?

A. I talked to them right after the child died, to tell them the child had died.

Q. That was sometime on March 9, 1981?

A. Just after the child had died.

Q. All right.

Then you told Mr. Hunt what you did after that. But I gather that from March 9th up until the time of the police investigation there was nothing to prevent you from accessing





BB18

1  
2 the medical records of the child?

3 A. There was nothing.

4 Q. Right.

5 And then do I take it what you  
6 are saying is once the Coroner became involved  
7 and the police became involved the medical records  
8 were no longer available to you?

9 A. That is correct.

10 Q. You were aware of the  
11 fact that there was a copy of the chart remaining  
12 at all times in the Hospital?

13 A. No, I was not aware. I  
14 was told there was nothing available to me.

15 Q. And who told you?

16 A. I am not sure who it was.  
17 I was told that all records were subpoenaed and  
18 were in the hands of the police and that we had to  
19 wait until this investigation was completed.

20 Q. Well, I am concerned with  
21 respect to that. You say all of the records were  
22 subpoenaed. Subpoenaed for what?

23 A. I don't --

24 Q. There were no charges with  
25 respect to Hines. Why do you say that you felt that  
they were subpoenaed?







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MR. ROLAND: She said she thought they were subpoenaed because someone told her that.

MR. PERCIVAL: Q., Who told you?

A. I'm not sure who it was but we were told in Cardiology that there was a police investigation and we wrote to each one of our patients to inform them of this and that we would be able to give them no further information or as soon as such information became available we promised that we would let them know.

Q. Did you write to Mr. and Mrs. Hines?

A. I wrote to Mr. and Mrs. Hines on April 3rd to tell them that I regretted very much --

Q. What did you tell them? What does your letter say?

A. Would you like me to read the letter?

Q. By all means.

A. I said:

"I am distressed that because of recent tragic events in the Cardiac Ward of the Hospital I feel compelled to write to you





BB202

about Jordan's death.

At the time the matter of his heart problem and the cause of death (that is as I understood it) was explained to you but I realize that you may now have new questions and concerns.

The police are conducting an extensive investigation into deaths on the Cardiology Service and should any new information become available you may rest assured that I will be in touch with you.

I and all the Cardiology staff deeply regret that these developments may have caused you further distress.

Yours very sincerely,"  
and I have signed it and Dr. Izukawa has signed it.

—





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MR. PERCIVAL: Could we have that marked as an exhibit, please.

THE COMMISSIONER: Yes, Exhibit 191.

--- EXHIBIT NO. 191: Letter to Mr. and Mrs. Hines from Dr. Vera Rose.

MR. PERCIVAL: Q. Now, Doctor, you have indicated at least in that letter to Mr. and Mrs. Hines that ---

THE COMMISSIONER: Excuse me just a minute, Mr. Percival.

MR. PERCIVAL: I am sorry.

THE COMMISSIONER: Perhaps if you can just pass it to me.

MR. PERCIVAL: You need to get a conveyer belt up there, Mr. Commissioner, would that be of some assistance, would the Municipal Board object?

THE COMMISSIONER: Yes, I think we should saw this thing in half, either that or get a couple more commissioners. All right. Do you want this --- Yes, Mr. Olah, do you have a solution to that?

MR. OLAH: No, I just wondered what number it is?

THE COMMISSIONER: It is No. 191.





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MR. OLAH: Thank you, Mr. Commissioner.

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THE COMMISSIONER: And that will be distributed and I guess one copy perhaps might come back to Dr. Rose for her files.

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MR. PERCIVAL: Q. You expressed in the third paragraph of Exhibit No. 191:

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"That should any new information become available you may rest assured that I will be in touch with you."

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That was on April 3rd, 1981. Did you at any time ever discuss it with Sergeant Press and Sergeant Warr, their investigation?

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A. I am not sure what you mean, Mr. Percival.

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Q. Well, you indicated that under the circumstances that:

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"The police are conducting an extensive investigation into deaths and should any new information become available you may rest assured that I will be in touch with you."

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It is a very simple question. Did you ever pick up a phone and phone Sergeant Warr, or Sergeant Press and find out what they found out about the death of Baby Hines?







CC. 3

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A. No, I thought they would come to me and let me know.

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Q. So do I take it that you had no communication whatsoever with respect to the police at any time, with respect to the death of Baby Hines?

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A. They came to me and asked me some questions but that was many months after.

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Q. I am talking about Baby Hines. Did you ever pick up the phone and solicit information from them?

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A. No, I thought they were investigating it and it would take them time to get that information.

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Q. Do I take it the only person up to this point in time, subsequent to the time of the baby's death and when you spoke to them and wrote this letter, the only other person that spoke to them was Dr. Fowler and that was after the Preliminary Hearing?

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A. Right. I think everybody knew what the investigation was about.

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Q. Well, excuse me, Doctor, the Preliminary Hearing had to do with the death of four babies at least those were the charges?

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A. Yes.

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Q. Did you think that the death of Baby Hines was being investigated as a homicide?

A. This is what it appeared to me this is what this ---

Q. Appeared from what?

A. From the news media this is what I was distressed about.

Q. I am distressed that you feel you were misled by the press.

A. I am not saying I was misled but I heard from the press what the feelings were of the coroner and what the parents were told.

Q. I suppose you never spoke to the parents, so you don't know what they were told, or what they were not told?

A. I didn't speak to the parents, because I would only speak to them if I had any information concerning their child's demise.

Q. Well then, when you did get the autopsy report, did you pick up the phone, or write Mr. and Mrs. Hines and advise them of it?

A. No, this was up to Dr. Fowler.

Q. Oh, all right.

A. This was for my own personal concern, I wanted to know what this child died of.





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Q. You have indicated this morning that you assisted in the review of the charts, and participated in meetings in order to prepare Dr. Rowe to give evidence. Did you make any notes of those meetings?

A. There weren't any meetings. There was one meeting in which we decided who was the most knowledgeable about each particular patient, who knew most, and who would look at the chart and prepare a summary for Dr. Rowe, one meeting.

Q. Did you ---

A. The second meeting was when we produced, each of us produced a summary and checked them to make sure there wasn't any other input anyone had.

Q. Did you keep a note of those meetings, it is a very simple question?

A. No.

Q. Did you prepare any notes with respect to any of those charts of the 36 children with which we are concerned?

A. I prepared one or two of the summaries.

Q. Where are the summaries?

A. I have the summaries, not here.





CC.6

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Q. Can you produce them, please?

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MR. ORTVED: I object, Mr. Commissioner.

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MR. PERCIVAL: Mr. Commissioner, you

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know, with respect we are talking about notes, and

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notes, and notes, why is there an objection?

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THE COMMISSIONER: It is an old

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fashioned objection and it may have something to do

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with the request of counsel for litigation, pending

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litigation, I don't know.

11

MR. PERCIVAL: This is a Royal

Commission, I understand.

12

THE COMMISSIONER: I think the Act, and

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maybe we haven't got the Act, but I think if this is

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a privilege that privilege may last.

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I have one point, the problem did come  
up and I don't know who it is, I think it was Mr.

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Labow wanted to have the summaries and I made at

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least a tentative ruling to the effect, and Miss

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Chown I think objected. I made a tentative ruling

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that I thought --

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MR. PERCIVAL: One of the concerns I

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have, Mr. Commissioner, with that sort of thing, that

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if my friend Mr. Ortved takes the position that is

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privileged, why did Miss Lund's notes come roaring

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out of the woodwork last Thursday afternoon?

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THE COMMISSIONER: I think those were made contemporaneously and I am not too sure if they were made with a view to litigation, were they?

MR. PERCIVAL: They were involved in an active coroner's investigation at that point, they were over at the Chief Coroner's office. I would have thought under the circumstances, and if Miss Lund thought it was a "tempest in a teapot" and at the end of it she felt something sinister was going on, I would think under the circumstances there might be privilege attached.

THE COMMISSIONER: There might be, but the answer to the whole problem is it wasn't raised. That is one answer to it.

MR. PERCIVAL: Well, if it is helpful to the Hospital we will put it in, but if it might be harmful therefore we will hold it back.

THE COMMISSIONER: You can always put anything - you can always weigh the privilege if you want to.

MR. ROLAND: I want to make one thing clear.

THE COMMISSIONER: Yes, Mr. Roland?

MR. ROLAND: My friend's last comment, first of all, it doesn't seem to me Miss Lund's notes





CC.8

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2 were privileged in any event, no one was involved in  
3 any litigation.

4 THE COMMISSIONER: No.

5 MR. ROLAND: And secondly my friend  
6 says, if it is helpful to the Hospital that will be  
7 held back. We have not seen the notes that are  
8 referred to here. They were prepared, as I understand  
9 it, for Mr. Ortved at his instructions and he has  
10 taken the position they are privileged as far as we  
11 are concerned as well and the Hospital hasn't seen,  
12 or at least counsel has not seen those notes either.

13 THE COMMISSIONER: Well at the moment  
14 Mr. Percival, the production is objected to.

15 MR. PERCIVAL: I don't know the basis  
16 of it, but perhaps Mr. Ortved can tell me.

17 MR. ORTVED: I haven't been able to  
18 get a word in edgewise.

19 MR. PERCIVAL: Go ahead.

20 MR. ORTVED: Mr. Commissioner, as was  
21 made clear last week by Miss Chown, I take the  
22 position that those notes are privileged, on the basis,  
23 as was made clear in Dr. Fowler's evidence, that they  
24 were prepared for my assistance, at my request, and  
25 at a time subsequent to the calling of this Inquiry.  
As has also been indicated by Dr. Fowler and Dr. Rose





CC.9

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2 here today, with a view to assisting Dr. Rowe in  
3 terms of his testifying when in fact he had to cover  
4 all these 36 cases, and clearly there is a privilege  
5 attached to them. That privilege is protected under  
6 the Public Inquiries Act, and everything you have  
7 heard about those summaries to date reinforces that  
8 purpose.

9 THE COMMISSIONER: Yes.

10 MR. ORTVED: I am not going to ask  
11 Mr. Percival to produce all of the notes that pertain  
12 to his confidential meetings with Sergeants Press  
13 and Warr and the rest of his officers on the same  
14 basis that those are privileged, and they are in no  
15 way comparable to the notes made at the meeting of  
16 March 21.

17 THE COMMISSIONER: I don't know who will  
18 suffer the most from this, I suspect there were a  
19 great many notes made by the police thereafter with  
20 a view to this Inquiry, or other inquiries, and I  
21 don't know. Anyway, Mr. Percival, do you want to  
22 answer that?

23 MR. PERCIVAL: I gather, Mr. Commissioner,  
24 you have ruled against me on the matter.

25 THE COMMISSIONER: No, I haven't ruled  
against you yet, I was offering you an opportunity  
to say something.





CC.10

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MR. PERCIVAL: Mr. Commissioner, you have indicated to me pretty clearly I am not likely to get it, and my friend has objected on the basis of privilege.

THE COMMISSIONER:

If I have done that it was unconscious, but it demonstrated my feelings. Yes, you are quite right, I was going to rule against you unless you persuaded me strongly that was so.

Before I finish with that ---

MR. PERCIVAL: Mr. Commissioner, I just wanted to know the volume of this evidence because I may rely upon that undertaking by my friend.

THE COMMISSIONER: You may well rely upon it, and I can see that this may be a ruling that you don't really want to win because of the effect it might have on you, but you don't need to answer that question.

Does anybody else support Mr. Percival's position on the production of these summaries? I just want to hear from you if you do before I make the ruling, that's all.

MR. PERCIVAL: It is an overwhelming vote of confidence from my brothers and sisters.

THE COMMISSIONER: I take it, I will then rule they need not be produced at this hour.









CC.11

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MR. PERCIVAL: Thank you.

3

THE COMMISSIONER: All right, now ---

4

MR. PERCIVAL: Q In any event, Doctor, you say you assisted in the review of the charts. Do I take it, at the end of which, before Dr. Rowe gave evidence involving the 36 baby deaths, there was a consensus at the meeting as to what the feelings were of the collective cardiologists that attended the meeting?

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A Mr. Percival, I think Dr. Fowler stated, and I will support his statement, the only consensus we had was regarding the problem these children had, the main problem, namely the cardiac problem.

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Q Then I will go to the evidence of Dr. Rowe, and dealing with Volume 18, pages 3275; and later at Volume 19, page 3293. The evidence of Dr. Rowe is that Baby Justin Cook was unquestionably the victim of digoxin intoxication?

19

20

A I cannot say anything about that patient because I was not there at the time.

21

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Q Do I take it that of the seven babies that Dr. Rowe felt were, or might be the victim of digoxin intoxication, Cook, Miller, Pacsai, Estrella, Inwood, Belanger and Hines, and the only





CC.12

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one you were involved with is Hines?

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A. That is correct.

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A. That is correct.

Q. So what you are saying I gather is this, that you prefer to express no opinion whatsoever involving the six that you were not involved with?

A. I don't know what meetings you are talking about.

Q. Are you ever, ever influenced by opinions of your brother cardiologists, or sister cardiologists?

A. I am not influenced by them, but we discussed, being a teaching institution, we discuss all our patients amongst us but that doesn't mean we influence each other, I think we bring our opinions together and I think the patients benefit that way.

Q. Do you defer to the opinion of Dr. Rowe in relation to the six then, that you were not connected with?

A. I was not connected with those six.





CC.13

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Q. Do you defer to his opinion?

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A. I cannot make any comment on that.

4

Q. I guess that is the privilege

5

of a woman.

6

A. Maybe.

7

Q. Not yes, not no, but I prefer not

8

to say anything.

9

MS. CRONK: It may be a bigger problem

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than you realize in a moment, Mr. Percival.

11

MR. PERCIVAL: Q. Do I take it no

12

matter how many times I ask the question, Doctor, I  
am not going to get an answer?

13

A. What are you asking again?

14

Q. I am asking if you defer to the

15

opinion of Dr. Rowe with respect to the cause of  
death of the six that you had no connection with?

16

A. I think all I have, all the

17

knowledge I have of these patients is what other  
people have told me.

18

19

Q. I didn't ask you that, Doctor. I

20

am saying if you had nothing to do with these six,  
and Dr. Rowe presumably had something to do with  
these six, do you defer to his opinion?

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A. If you would like a "yes" answer

23

you will get it.

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CC.14

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Q. Tell me, a "yes" or "no" answer,  
whatever you prefer.

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A. Yes.

5

MR. PERCIVAL: Thank you.

6

THE COMMISSIONER: I just want to make  
sure, I don't know the six, to the six was added  
Lombardo, Lombardo did have - so there really are  
seven.

9

MR. PERCIVAL: Seven, that's right.

10

THE COMMISSIONER: Including Lombardo,  
and I would have thought ---

12

MR. PERCIVAL: Estrella was in there  
but it had nothing to do with digoxin as I understand.  
Velasquez?

13

14

THE COMMISSIONER: Velasquez, yes. Well,  
I don't know, Velasquez was not one of Dr. Rowe's ---

15

16

THE WITNESS: No.

17

THE COMMISSIONER: One of his patients?

18

THE WITNESS: No.

19

THE COMMISSIONER: But Lombardo was?

20

THE WITNESS: This wasn't my patient  
but I was involved --

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THE COMMISSIONER: No, no, but you did  
know something?

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24

THE WITNESS: Yes, I did know something  
about Lombardo.

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CC.15

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MR. PERCIVAL: Q. All right, let's  
deal with Lombardo.

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MR. STRATHY: If I may, Mr. Commissioner.

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THE COMMISSIONER: Just a moment,  
Mr. Strathy, yes.

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MR. STRATHY: I think, just to complete  
the list if my friend is going to add Belanger he  
should also add Murphy which is one of the ones  
Dr. Rowe suggested in light of the digoxin evidence  
he would add to his list.

11

12

THE COMMISSIONER: I don't remember  
that.

13

14

15

MS. CRONK: To help you, Mr. Commissioner,  
with respect to my friend, I don't have any  
recollection that Paul Murphy was added to the list.

16

17

18

MS. CRONK: The list of names from  
Dr. Rowe's evidence were Justin Cook - are you  
referring to Gary?

19

MR. STRATHY: Yes, I am.

20

MS. CRONK: Oh, I am sorry, I thought  
you meant Paul Murphy.

21

22

MR. STRATHY: No, no, Gary Murphy.

23

THE COMMISSIONER: Gary Murphy is the  
one who died in 1983.

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CC.16

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MR. STRATHY: That is so, and Dr. Rowe suggested the ones he would have concern about he would add Gary Murphy to that list because of the digoxin levels. He also subsequently added Belanger to that list.

MS. CRONK: I apologize to my friend, I thought he was referring to Paul Murphy.

THE COMMISSIONER: Yes. All I was trying to point out before we got involved in all of this was I thought Lombardo was one of the ones that Dr. Rose dealt with and she did, it was Stephanie Lombardo.

THE WITNESS: Yes.

THE COMMISSIONER: And therefore that is one of the ones and perhaps you can follow that further.

MR. PERCIVAL: Thank you, Mr. Commissioner.

Q. Dr. Rose, can you tell me, you were involved with Hines. Were you involved with Lombardo?

A. Only after Lombardo died, Stephanie died during the night as you know, and after she died I came in and spoke to the parents and reviewed the chart.





CC.17

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Q. You were ward chief then?

3

A. No.

4

Q. Well, can you express an opinion with respect to the relationship between digoxin intoxication with respect to either Baby Hines or Baby Lombardo?

5

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A. All I can tell you is that neither of these two children were receiving digoxin, they were not prescribed digoxin. At the time of their death I had no concerns about digoxin.

10

11

Q. And if digoxin was found in their tissues post mortem, does that cause you any disquietude?

12

13

A. Absolutely it does.

14

MR. PERCIVAL: Thank you, no further questions.

15

THE COMMISSIONER: Yes, Miss Symes.

16

CROSS-EXAMINATION BY MS. SYMES:

17

Q. Dr. Rose, simply following up on that, is that area, that is the finding of digoxin in postmortem tissues, still an area that you think for your information requires further concern?

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21

A. Yes.

22

Q. Dr. Rose, I understand then that you were ward chief for some period in July?

23

A. That is right.

24

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CC.18

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Q In 1980, and that was the only time that you were ward chief during the epidemic period?

5

A. Apparently.

6

Q. Apparently?

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A. I can't remember.

8

9

10

Q In the summer of 1980, up to September 5 of 1980, did any member of the nursing staff on Wards 4A/4B come to you with their concerns of the number of arrests and deaths on the ward?

11

A. No.

12

13

14

Q Did you have any conversations with respect to the fact that the number of deaths were increasing, that is in this particular period of time?

15

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A. Yes, we were concerned about the numbers of deaths on the ward.

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Q. Who were your conversations with?

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A. The cardiologists mainly, but I think we talked to the nurses as well. I can't recall exactly, but I think we all talked about it, we felt we should review the deaths ourselves and see how sick the babies were. To reassure the nurses as well who were feeling very badly that these children were dying who wondered if they had done everything they could for these children.







CC.19

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Q. So before that September 5th meeting then, you knew that the nurses were concerned about the numbers of deaths and the number of arrests?

A. Oh yes. Nurses are always concerned when they lose a child, very much so.

Q. Did you gather that their concerns were twofold. No. 1 is perhaps they were missing something in the period immediately before death, that if they noticed would save the child?

A. This was probably one of their concerns.

Q. And the second concern was since so many of the arrests had been unsuccessful, was there something that should be done, either done differently, or done more during the resuscitation attempts to try and have more successes?

A. That particular aspect I don't recall but they were certainly concerned as to what could be done to prevent deaths on the ward.

Q. So I gather then that these concerns from the nurses were known to you before you went into the meeting on September 5th?

A. Yes.

Q. And you are not sure if they came from fellow cardiologists or from the nurses themselves?





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A. I am not sure.

Q. Were you aware at the time that the number of resuscitation attempts were - that a number of the resuscitation attempts were unsuccessful?

A. Well, obviously, because the children died.

Q. I presume that one of the experiences had been, on the ward, that you were able to resuscitate the children and to move them to the Intensive Care Unit?

A. Oh yes, that certainly happened.

Q. And that although the eventual course for the children was that they would be resuscitated, they would die on the ICU?

A. That happens also.

Q. Because it is a very standard pattern, isn't it, Doctor, that although you may be able to resuscitate a child, that death follows shortly thereafter, that is within 24 hours?

A. Yes, it all depends on what the child's original problem was, how sick the baby was to start with and all of these other factors and which one of these many factors was also involved.

Q. So for example, when we are looking at Exhibit 125, the difference may be that





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after the resuscitation had taken place on Wards  
4A/B, the deaths may be recorded in the ICU as  
opposed to Wards 4A/4B?

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A. That is correct.

6

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Q. Were you aware then of the  
concern that the deaths were occurring on the ward  
as opposed to say the ICU?

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A. We were mainly concerned about the  
deaths that occurred in these very sick babies.

10

11

Q. So where they occurred as far  
as you are concerned was not a particular concern?

12

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A. It was as well because we were  
thinking at the time of establishing a more intensive  
area where the children could be looked after more  
intensively on the ward.

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Q. Were you aware that the concerns  
were that the deaths were at night?

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Q. And were you aware that it was occurring on the same team?

A. Not at all.

Q. That had never been brought up to you by the nurses themselves?

A. No.

Q. Would you agree with me that the meetings with the nurses that were held on September 5th and 26th were unusual or rare?

A. I recall these meetings specifically to discuss the nature of the children's heart problem and the way they died.

Q. I understand that is why you called them but I am asking you to call those kinds of meetings where the cardiologists sit down formally with the nurses was that unusual and rare?

A. Yes, it was unusual at the time.

Q. Now, I am asking you from the period of September 26th forward until you went on holidays on March 20th, 1981, during that particular period did any nurses come to you with nursing concerns about the number of arrests and deaths?

A. No. I don't recall.

Q. You don't recall. You had mentioned in your evidence that it was your perception







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that there was a shortage of nurses at night?

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A. Yes.

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Q. And you say, am I putting it

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fairly that your only source of that is that when

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you walked on at nights there didn't appear to be as  
many nurses as during the days?

7

A. That's correct.

8

Q. Were you involved in the

9

planning of the move of the ward from floor 5 to

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floor 4A/4B?

11

A. No.

12

Q. Did you as cardiologists have

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any input into the changes which occurred?

14

A. No.

15

Q. Were you aware of the

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decision to increase the number of beds?

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A. Yes.

18

Q. And were you aware that that

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would come with it an increase in the number of nurses  
to look after those increase in beds?

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A. I would presume that would have

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happened but I wasn't aware of just what the numbers  
of nurses were in relation to beds.

22

Q. But were you aware that there

23

was an increase?

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25





1 A. Yes.

2 Q. And I gather also that the mix  
3 of beds between infant and children changed?

4 A. Yes.

5 Q. In other words that the  
6 proportion of infant beds was increased?

7 A. Right.

8 Q. And were you aware that there  
9 was a corresponding change of an increased nursing  
10 coverage at nights to correspond to the increasing  
11 proportion of infant beds?

12 A. I was not aware of that.

13 Q. Does that surprise you if I  
14 tell you that that is in fact our evidence?

15 A. Yes. I heard that since. It  
16 did surprise me at the time but I know about it now,  
17 yes.

18 THE COMMISSIONER: I'm sorry, it did  
19 surprise you. I thought you said that you presumed  
20 that there would be more beds and more nurses, but  
21 you didn't presume that, I misunderstood you.

22 MS. SYMES: I think it was a separate  
23 question, Mr. Commissioner.

24 THE COMMISSIONER: You presumed there  
25 would be an increase in beds but not an increase in  
nurses?





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THE WITNESS: I would presume that the increased nurses would follow the increase in beds.

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THE COMMISSIONER: Well, that's what I would presume too but I think you said exactly the opposite to Miss Symes.

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MS. SYMES: No, there is a second question. She agreed with the first. The second question was, because the proportion of infant beds was increasing were you aware of a corresponding decision to increase the nursing coverage at nights?

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A. I wasn't aware of this particular decision but I would again presume that there would be a nursing increase, an increase in nurses.

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Q. So, it wouldn't surprise you that the nursing coverage was increased because the needs of neonates and small infants are essentially constant throughout a 24-hour period?

19

20

21

A. Yes.  
Q. Okay. And when the ward moved from floor 5 there was one ward and one head nurse, is that correct?

22

23

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A. Yes, I believe so.

Q. And in April of 1980 then it





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became two wards with two head nurses?

3

A. Yes.

4

Q. So, it increased the number  
of nurses in administration?

5

A. Correct.

6

7

Q. And also in the summer of 1980  
I understand that you went from one clinical nurse  
specialist to two?

8

9

A. Yes.

10

11

Q. And that person deals with the  
families, is that right?

12

A. That's correct, yes.

13

Q. Now, you said that ---

14

THE COMMISSIONER: That's surely not all  
that she does. She deals with the families and ...?

15

16

THE WITNESS: The two nursing  
specialists dealt mainly with the families and the  
children as well, explaining to the parents the surgery  
and the various procedures that they were doing but  
they were mainly family support nurses. They were  
not nurses in the way of giving daily care nursing.

20

21

THE COMMISSIONER: Would they be  
qualified nurses?

22

23

THE WITNESS: Very specially qualified  
in giving family support. They are fully qualified,

24

25







1

2

yes.

3

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MS. SYMES: Q. In fact, they were  
extremely well qualified, well trained?

5

A. Yes.

6

7

Q. And we've got from Dr.  
Freedom that they also acted as a liaison between  
nursing and medicine?

8

A. That's correct.

9

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Q. With respect to problems that  
these children had?

11

A. That's correct.

12

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Q. And one of their functions I  
gather is to try and ensure continuity of care for  
the parents?

14

A. That's correct, yes.

15

16

MS. SYMES: Mr. Commissioner, should I  
take my break at this time?

17

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THE COMMISSIONER: Well, if you like,  
is this a suitable time?

19

MS. SYMES: Yes.

20

THE COMMISSIONER: We will take 15  
minutes then.

21

---Short recess.

22

---On resuming.

23

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THE COMMISSIONER: Just before you  
start, Miss Symes. Mr. Brown, I understand that

25





7 1  
2 you've got some problems relating to the, I don't  
3 know, statements that should or should not be produced  
4 with respect to the form of the hearing and Mr.  
5 Sopinka has asked for time to argue the matter. Is  
6 that right?

MR. BROWN: Yes, Mr. Commissioner.  
7  
8 I think last week he in effect put people on notice  
9 and would ask there be some period of time set aside.

THE COMMISSIONER: Well, I tell you,  
10 I don't want to set aside any time that is unnecessary  
11 because God knows we'll need all the time we can get.  
12 But if I know there is a real problem I am prepared  
13 to set aside time for the arguments. So, what I'm  
14 going to suggest to you is that some time at 4:30  
15 next week you or Mr. Sopinka or whoever is going to  
16 come appear and tell me what the problem is and if  
17 we can't solve it right then and provided there is  
18 something in it I will set aside some time for  
19 argument, but I am not persuaded that it is a real  
20 problem yet.

MR. BROWN: Well, I think there are  
21 differences in opinion and there is perhaps a mis-  
22 understanding or a need for further clarification of  
23 your ruling last week. So, I think an opportunity  
24 to address the issue is needed.  
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THE COMMISSIONER: All right. Well, let's make it 4:30 any time next week, Monday to Thursday but would you let us know ahead of time so that anybody who is interested in those two problems will be there.

MR. BROWN: Fine. I will notify you as soon as possible.

THE COMMISSIONER: Yes, all right. Perhaps tomorrow morning you might be able to.

MR. BROWN: I don't anticipate any difficulty. Please don't hold me to that, Mr. Commissioner, but certainly by the end of the week.

THE COMMISSIONER: No, no, but it is certainly something to work on. All right.

MR. BROWN: Yes.

THE COMMISSIONER: Yes, Miss Symes.

MS. SYMES: Q. Dr. Rose, were you aware that the nurses worked in teams?

A. Yes.

Q. You had said that you were not familiar with the term constant care?

A. Right.

Q. It may be that you are not familiar with the term but I'm going to hope that you in fact understand that there were different things





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that you as doctors ordered with respect to the care provided to children who needed closer attention than normal.

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A. I personally never put in such an order.

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Q. Okay. If you had a child whom you thought needed special care, that is, close monitoring, I gather one of the things that you could do was try and get that child transferred to the Intensive Care Unit?

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A. Yes. I would speak with the head nurse and we would discuss it and then we would make a decision as to whether this child could be properly looked after where the child was or whether it needed to be transferred; not only the nurses but the residents and the fellows and everyone concerned.

16

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Q. And if there was a decision to try and keep the child on the ward then you would be seeking a greater or closer nursing observations for that child?

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A. Yes.

Q. Okay. And I presume if you asked for it nursing tried to accommodate it?

A. That's right. What would happen is we would tell the head nurse that we think this







Rose, cr.ex.  
(Symes)

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child will need close observation and she would then take the steps to either get more nurses or get more care provided for this child.

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Q. But I gather the thing that was available in the Intensive Care Unit that was not available on the ward even with special nursing care was greater medical coverage?

8

9

10

11

A. I'm sorry.

Q. That is, more doctors present at all times in the Intensive Care Unit than on 4A/4B?

12

13

A. Medical coverage and nursing coverage. It was a one-to-one situation in Intensive Care, it is quite different.

14

15

16

Q. I gathered though on the ward you could get one-to-one nursing coverage if you wanted it?

17

18

A. I'm not sure that we could, but maybe that's true.

19

20

21

Q. During the epidemic period do you agree that there were problems with respect to the over-crowding or over-utilization of the Intensive Care Unit?

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A. I wasn't aware of it at the time.





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Q. You were not aware of it?

3

A. No.

4

Q. Did you have any trouble or  
did you hear of trouble of transferring babies from  
the ward to the ICU?

6

A. It may have occurred in an  
individual situation but it wasn't an overall  
impression of trouble with the ICU or anything like  
that.

10

Q. Okay. And were you aware of  
any problems of getting the babies back from the ICU  
ahead of ideal time?

11

12

A. I think this sometimes happens.  
I think if the ICU was pressed for beds they would  
try and transfer a child up a little bit sooner.

14

15

Q. Okay.

16

A. This was always discussed.

17

Q. But I gather if that happened  
that would put a strain on all of the people on 4A/4B?

18

19

A. Yes, it would.

20

Q. Okay. Now, you talked about  
a cluster and you answered questions from the  
Commissioner. I gather that clusters can occur, first  
of all because there is a reason, that is, an underlying  
reason such as, for example, I want to take you to a

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specific one, when there was a clustering of abnormalities in children that was later led back to thalidomide.

A. Yes.

Q. That then explained the cluster that occurred with respect to deformities.

A. That's correct.

Q. Do you also agree with me that clustering can occur at random, that is, with no explanation?

A. It does occur at random, yes.

Q. And no matter how far you search there is no established reason and it is simply a statistical accident?

A. Yes.

Q. Hines, one of the babies that you were involved with, there is a diagnosis or a possibility of SIDS, Sudden Infant Death Syndrome.

A. Yes.

Q. Is it true that that is a very common cause of death in young children?

A. I'm not sure whether it is very common, but it is a cause of death in young children.

Q. We have been given literature





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that says that it is in fact the most common cause of death in children under one year of age and in fact it accounts for more deaths than any of the other causes put together.

A. I wasn't aware of that.

Q. But it is not a rare phenomenon?

A. No.

Q. Okay. Experienced all over the Province of Ontario?

A. Yes.

Q. And certainly experienced in the City of Toronto?

A. Yes.

Q. Do you agree with me that the Hospital for Sick Children is recognized as world experts in research into Sudden Infant Death Syndrome?

A. Yes.

THE COMMISSIONER: You are asking for an immodest reply?

MS. SYMES: An immodest reply. Since the Hospital didn't put this in I thought it was fair that someone mentioned that.

THE COMMISSIONER: Yes, all right.

MS. SYMES: Q. And in fact all autopsies







Rose, cr.ex.  
(Symes)

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on Sudden Infant Death Syndrome, that is suspected Sudden Infant Death Syndrome in the whole of the Metropolitan or Greater Metropolitan area is done at the Hospital for Sick Children?

A. Yes, yes.

Q. So that of all the hospitals or all the pathologists in Ontario the Hospital for Sick Children has the most experience?

A. Yes.

Q. I understand that whereas most sudden infant deaths occur at home, do you agree that that is in fact true?

A. Yes, I think that is true.

Q. I gather you say it is your experience that SIDS deaths do occur in hospitals?

A. Yes.

THE COMMISSIONER: I am sorry. That may be her experience but I thought you also said that you had never experienced it.

THE WITNESS: Not on the Cardiac Ward.

MS. SYMES: Q. But at the Hospital for Sick Children are you aware that SIDS deaths have occurred while the children are in the hospital?

A. I think they have, yes.

Q. Even in a teaching hospital?





1  
15 2 A. What do you mean by even in  
3 a teaching hospital?

4 Q. Well, you know, even with the  
5 greater degree of sophistication that occurs in a  
6 teaching hospital.

7 THE COMMISSIONER: I just don't want  
8 to have Dr. Rose bullied into these answers. You are  
9 free, you don't have to agree with counsel. Do you  
10 know of any SIDS deaths, leaving aside of course the  
Hines.

11 THE WITNESS: Yes.

12 THE COMMISSIONER: Do you know of any  
13 recognized, uncontested SIDS death that's taken place  
14 in the Hospital for Sick Children?

15 THE WITNESS: I don't recall one  
16 particular case but I have heard.

17 THE COMMISSIONER: Not particular but  
18 in any case of any kind.

19 THE WITNESS: I think they have  
20 occurred.

21 THE COMMISSIONER: You think they have  
22 occurred, all right, thank you.

23 MS. SYMES: Q. And do you agree that  
24 whereas most SIDS occur after one month of age that  
25 there have been SIDS occur in neonates, that is,





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children less than one month of age?

3

A. I believe that is in the

4

literature.

5

Q. Okay. Now, this particular

6

child, Hines, in Exhibit No. 103, which is the chart,

7

I gather you have reviewed the records before you  
come.

8

A. Yes.

9

Q. Perhaps you might not have to

10

refer to this but I see on page 76 that the doctor

11

ordered an apnea monitor?

12

A. Yes, that's correct.

13

Q. And that is the admission

14

order, is it, that the child be placed on an apnea  
monitor?

15

A. I believe so.

16

Q. I gather also a cardiac monitor?

17

A. That's right.

18

Q. Dr. Rose, apnea monitors are

19

given to children whom there is a concern that

20

sudden infant death might occur. Do you agree with  
that?

21

A. Apnea monitors are given to

22

children who have a history of apnea.

23

Q. Okay. And children who have

24

25





17 1 a history of apnea are candidates for SIDS?

2 A. Yes, that's generally recognized.

3 Q. And in fact that order was  
4 carried out, and I think it is on page 66 of the  
5 progress notes. Just so as I understand it, these  
6 apnea monitors, do they measure failure to breath?

7 A. Yes.

8 Q. And is it essentially an alarm  
9 system that goes off so many seconds of failure to  
10 breathe?

11 A. I think so, yes.

12 Q. And the alarm system is  
13 sufficiently loud that it alerts whoever is in the  
14 area?

15 A. Yes.

16 Q. To come and act quickly?

17 A. Yes.

18 Q. Okay. And on page 66 of the  
19 chart, I believe it is the third line that there  
20 is measuring of apnea?

21 A. Yes.

22 Q. That's the admission note?

23 A. On page 66?

24 Q. Page 66 on the third line from  
25 the top.







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A. Yes, apnea, brady - I think that must be the admission note.

Q. The admission note, yes. And then moving down to the next handwriting, 6/3/81.

A. Yes.

Q. Still having apnea with bradycardia?

A. Yes.

Q. Would that have been measured then from the apnea monitor?

A. I don't know.

Q. All right. But it is still obvious that this child was still experiencing apnea attacks or apnea spells while in the hospital?

A. Yes, that's correct.

Q. And those apnea - are they called apnea spells?

A. Apnea spells, yes.

Q. Those are an indicia of SIDS, that is, if a child is having apnea spells there is a concern that SIDS might occur?

A. Yes.

MS. SYMES: Thank you, those are my questions.





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THE COMMISSIONER: Yes all right,  
thank you. Miss Jackman?

MISS JACKMAN: No questions, Mr.  
Commissioner.

THE COMMISSIONER: Mr. Olah?

MR. OLAH: No questions, Mr.  
Commissioner.

THE COMMISSIONER: Mr. Labow?

MR. LABOW: Sorry to disappoint you,  
Mr. Commissioner.

THE COMMISSIONER: No, no.

CROSS-EXAMINATION BY MR. LABOW:

Q. Doctor, could you tell me what  
your responsibilities would be as the on-call staff  
physician at the Hospital?

A. As the on-call staff physician  
I would be the cardiologist responsible for the  
patient during that period of time that I was on  
call.

Q. Now, I understand from the  
evidence to date that you are not necessarily in  
the Hospital?

A. That's correct. If it is the  
night time I would not stay in the hospital.

Q. Or a weekend necessarily?





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A. Yes, necessarily. It depends on what is happening.

Q. Now, when would you generally be called?

A. I would be called if there was any problem with a patient or if there was any concern or questions or any referral from a referring physician, an outside physician that their child had a problem that he wanted to discuss or if he had a patient he wanted admitted he would be in touch with me and I would then communicate with the people who would admit the child.

Q. Well, you would be called by whom?

A. I might be called by the people on locating to give me the name of the physician and the number to call or they would transfer the call to me if it was an outside call.

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I might be called by the fellow who was on duty with the patient. I might be called by anybody, but usually it is somebody from the cardiology who calls.

6

7

Q. What kind of concerns generally would they call you about aside from an arrest?

8

9

10

11

A. Oh, many. They might have a sick child who needed some extra attention or they may have a question about a patient about medication. All kinds of cardiac problems they might be in touch with me about.

12

13

Q. If you were the on-call staff physician on a weekend?

14

A. Right.

15

16

Q. Do you go in at all during the weekend regularly, or do you just wait for a call?

17

18

19

20

21

A. No, I go in regularly. I make ward rounds on Saturday morning and on a Sunday morning, and sometimes I come in in the evening, depending on the type of problems we have on the ward.

22

23

24

25

If there are a lot of sick babies I would come in again in the evening, and I would make rounds in the Intensive Care as well, depending







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on the problems.

3

Q. Would you expect to be called  
if a fellow or resident suspected digoxin toxicity in  
one of the children?

5

6

A. Yes.

7

Q. While you were the on-call  
physician?

8

A. Yes.

9

10

Q. I would like to turn to  
Real Gosselin.

11

A. Yes.

12

Q. Now in the Gosselin case this  
baby was admitted to the Hospital on the 17th of  
December?

14

A. Right.

15

Q. And died early next morning?

16

A. Yes.

17

Q. On the 18th. Were you in  
the Hospital when this child was admitted do you  
recall?

19

20

A. I don't recall the admission  
at all. If it was in the daytime, I would have been  
there.

21

22

23

Q. This was a Wednesday or  
Thursday. This was during the week.

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A. Was it during the day or at night?

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Q. I am not sure from the note but I think it was early in the morning.

6

A. Yes.

7

8

Q. The first nursing note is at 7 o'clock in the morning?

9

A. Well, I would have come into the Hospital at 8:30.

10

11

Q. Now you wouldn't have routinely seen this child?

12

13

A. No, I was not in charge of this patient's care.

14

15

Q. But you were on call in my understanding that evening?

16

A. That is right. The night this child died.

17

18

19

Q. . Would you have reviewed the chart beforehand in any specific way or only if you were called in afterwards?

20

21

A. Only when I was called in about the child's arrest. That is the time I would review the chart.

22

23

Q. So in this case you were called that night?

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A. Yes.

Q. And your evidence this morning was that you reviewed the chart and spoke to the parents?

A. Right.

Q. Do you recall when you reviewed the chart?

A. I reviewed the chart when I came in. This is what I usually do when I am called about an arrest. Sometimes I know the child beforehand. I don't think I was very intimately involved with the care of this child.

Q. You say in your note at page 45, you arrived at about 3:20.

A. That is right.

Q. So you would have reviewed the chart at that point?

A. Right.

Q. Do you know when you spoke to the parents?

A. I am sure I must have spoken with them after I reviewed the chart.

Q. Well, would you wait for the morning or would you call them at 4 o'clock?

A. No, I think they are always





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called when a child dies and they came in and I  
talk to them.

3

4

Q. Do you recall what you told  
them?

5

6

A. I don't actually recall, but  
what I usually do is I try and explain what I think  
might have occurred based on what I read on the  
chart. And then I explain the autopsy procedure  
and how important it is to do it.

7

8

9

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Q. Now you pointed out today that  
as Dr. Freedom said the chart speaks for itself?

11

12

A. Yes.

13

Q. Would you explain that to me?

14

A. Okay. The child's chart - in

15

the chart the important points to be noted are the  
fact that despite the administration of prostaglandin  
in this case to keep the ductus arteriosus open

16

17

the child remained with a pressure differential

18

between the upper and lower limbs which means that

19

there wasn't much improvement in this gradient.

20

And so that is probably the prostaglandins were not

21

having the effect that we hoped that the prostaglandins

22

will have, namely improving the perfusion of the

23

lower half of the body and the kidneys.

24

So this child remained in severe heart

25

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EE5







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2 failure because of the obstruction caused by the  
3 narrowing in the main artery, and we felt that it  
4 was a severe narrowing or coarctation of the aorta  
5 which was the cause of the failure, and that is why  
6 the child died.

7 Q.<sup>1</sup> Now prior to writing your note  
8 at 3:30 in the morning do you recall who you discussed  
9 this case with?

10 A. I don't recall.

11 Q. Do you know if you spoke to  
12 the nurses?

13 A. I usually speak to the  
14 residents, the doctors and fellows. I don't speak  
15 to the nurses necessarily.

16 Q. Do you know who the residents  
17 were?

18 A. I know Dr. Lichtman wrote a  
19 note. I know him very well. I cannot read the  
20 other note. I cannot recall who that was.

21 Q. Are you looking at --

22 A. I am looking at the note that  
23 is written on the same page that my note is.

24 Q. Just above yours?

25 A. Yes.

Q. Is that possibly Dr. Steven?





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2

A. It could be, yes.

3

Q. Because he wrote a doctor's

4

order on page 54?

5

A. Yes.

6

Q. In this matter?

7

A. Yes.

8

Q. And it looks like the same

signature.

9

A. It could be Dr. Steven because

10

Dr. Lichtman and Dr. Steven --

11

THE COMMISSIONER: Dr. Mountstephen?

12

THE WITNESS: No, it is not

13

Dr. Mountstephen. I know this signature. This is

14

David Steven. That is right, he wrote out his name

15

more legibly next to the signature on the order

sheet.

16

MR. LABOW: Q. That is how I

17

recognized it.

18

A. Yes. He was asked to print

19

it actually.

20

Q. In your note you pointed out

21

there was no bradycardia? In your note on page 45.

22

at 3:30?

23

A. Yes. No bradycardia.

24

Q. But in Nurse Nelles' note at

25





EE8

1  
2  
3 page 47 she points out, four lines from the bottom  
4 of her note that the babe continued to be bradycardic.

5 And in addition in the discharge  
6 report written by Dr. Steven at page 21 and page 22  
7 he notes at page 22 that the baby did well until  
8 2:25 on the 18th, had a prolonged episode of  
9 bradycardia, that resolved spontaneously, and then  
10 five minutes later had another episode.

11 A. Yes. I think I must have  
12 referred to the fact I was concerned about the  
13 apnea and its relation to the prostaglandins which  
14 sometimes causes apnea, and maybe that was the  
15 time that the child did not have a bradycardia. That  
16 is in relation to the...I am not sure.

17 Q. Now you realize by your note  
18 that digoxin had been held because there had been a  
19 level of 3.9?

20 A. Right.

21 Q. Did you consider digoxin  
22 intoxication as a possible cause of this death at  
23 any time?

24 A. No, I thought it was unlikely  
25 since it had been held for more than 24 hours.  
Indeed I believe the child had some urine output so  
I don't think that is an excessive level. It is





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a high level but if digoxin had been held I wouldn't  
be too concerned about this level.

3

4

Q. So you weren't concerned  
because it had been held for a day?

5

6

A. That is right. More than a  
day I think.

7

8

Q. Now my review of the progress  
notes, and there aren't very many because the child  
wasn't there very long.

9

10

A. No.

11

12

Q. Indicates arrhythmias,  
bradycardia and vomiting.

13

A. Yes.

14

15

Q. In the day that the child  
was there. Aren't those common symptoms of digoxin  
intoxication?

16

A. They can be.

17

18

Q. We have heard from Dr. Freedom  
about his letter, his report that is found at page 35.

19

A. Right. Yes.

20

21

Q. Now in that note which  
Dr. Freedom has gone out of his way to indicate  
does not account for what he thinks today --

22

A. Yes.

23

24

Q. -- he pointed out at page 36

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EE9







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that he doubted that the death of this child could be explained on the basis of an apnea secondary to the prostaglandin therapy.

A. Yes.

Q. And that he didn't have a good explanation for the death.

At the time the doctor wrote his letter which was the day of the death --

A. Yes.

Q. -- what was your opinion?

Do you recall what your opinion was?

A. At the time the doctor wrote his note? Is there a date on that? I can only tell you what my opinion was when I saw the chart.

Q. Okay.

A. The time I came in.

Q. What was your opinion when you saw the chart?

A. My opinion was that this child was in severe failure and had a critical coarctation; there was almost an arch interruption, and these children are severely ill, may well die of severe heart failure; that this was the cause of the child's death.

Q. Do you recall talking to





1

2

Dr. Freedom?

3

A. Yes.

4

Q. I would assume it had to be

5

after he wrote this letter?

6

A. Yes, probably.

7

Q. Do you have any idea when

8

you spoke to him?

9

A. No, I can't recall.

10

Q. Did you attend at the autopsy

of this child?

11

A. No.

12

Q. Does it surprise you that

13

when this child came into the Hospital the first

14

nursing note points out the child was in no distress?

15

That is at page 43.

16

A. Had a respiratory rate of

66. That is not exactly quiet respiration.

17

Q. Well, at page 42 we have a

18

note from Dr. Lichtman, and this I understand is

19

the note that would be taken when the baby first

20

enters the Hospital?

21

A. Yes.

22

Q. The history at page 39 and

it continues?

23

A. Yes.

24

25





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Q. And at page 41 he points out  
no cyanosis, no plugging, not distressed.

4

A. Right .

5

Q. And then at page 42 --

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THE COMMISSIONER: I am sorry --

7

MR. LABOW: I'm sorry, page 41.

8

THE COMMISSIONER: 41?

9

MR. LABOW: General description,  
right at the top of the page.

10

THE COMMISSIONER: Oh, I see, yes.

11

MR. LABOW: Q. Then at page 42,  
CHF under good control.

12

13

A. Well, at that time he was  
one of our residents, and he was learning about  
heart failure. He also mentioned that the liver was  
5.5 centimetres below the costal margin. That is a  
very large congested liver, and that is one of the  
most significant signs of congestive cardiac failure.  
So this child was in heart failure.

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Q. And it wasn't under good  
control? Is that what you are saying?

20

21

A. It wasn't under good control.  
I would disagree with Dr. Lichtman, but he has to  
learn, and I am sure it was discussed with him.

22

23

24

25

Q. Do you recall disagreeing with





1  
2 him when you went through the chart?

3 A. I don't recall disagreeing,  
4 but this is how our fellows learn. It is pointed out  
5 to them that a child with a liver of 5.5 centimetres  
6 has to be in failure.

7 Q. Now do you have any idea who  
8 would have informed Dr. Freedom that the child was  
9 responding well to prostaglandin therapy?

10 A. It might well have been  
11 Dr. Lichtman.

12 Q. But you don't know?

13 A. I don't know, but he said he  
14 spoke to the residents on the ward, and he was one  
15 of the residents, so I'm just wondering if it might  
16 have been him. He is by the way a good pediatrician.

17 THE COMMISSIONER: We will have to  
18 give poor Dr. Lichtman one of those notices under the  
19 Public Inquiries Act.

20 MR. LABOW: Mr. Commissioner, I  
21 would be going on to another file now.

22 THE COMMISSIONER: Yes. All right  
23 then until 10 o'clock tomorrow morning.

24 MS. CRONK: Mr. Commissioner, might  
25 we have an indication or at least an approximation  
of time?







EE14

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THE COMMISSIONER: Yes, I think that  
is a good idea. What do you think?

4

MR. LABOW: 5 to 10 minutes,

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Mr. Commissioner.

6

THE COMMISSIONER: Mr. Tobias?

7

MR. TOBIAS: I would think about  
45 minutes, Mr. Commissioner.

8

THE COMMISSIONER: Mr. Shanahan?

9

MR. SHANAHAN: Mr. Commissioner, I  
should be about 45 minutes. It may be that you will  
want me to go next, and I won't be here sharp at  
10:00. Could Mr. Tobias go --

12

13

THE COMMISSIONER: No, I think  
Mr. Tobias got in ahead of you on the original.

14

15

MR. SHANAHAN: He got in ahead of  
me?

16

17

THE COMMISSIONER: Yes, so you  
have nothing to worry about unless, of course, he  
should fail to carry out his promise of 45 minutes.

18

19

And Mr. Shinehoft?

20

21

MR. SHINEHOFT: Bringing up the  
rear, Mr. Commissioner, I don't anticipate I will  
have any questions of this witness.

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THE COMMISSIONER: Well now I don't  
think there will be too much re-examination so you

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EE15

can react accordingly?

MS. CRONK: Thank you,  
Mr. Commissioner.

THE COMMISSIONER: I think it looks  
as though we might reach the next witness tomorrow  
morning. Do you not agree with that?

MS. CRONK: I suggest that it would  
be after lunch, Mr. Commissioner. We have got an  
hour and a half to two hours without hearing further  
from Mr. Ortved and Mr. Roland.

THE COMMISSIONER: Well, I didn't  
add that up that way but perhaps I am wrong.

MS. CRONK: I will speak to  
Dr. Becker and see what I can arrange.

THE COMMISSIONER: Well, you don't  
need to arrange anything but Dr. Becker is at the  
Sick Children's Hospital, isn't he? Is he?

MS. CRONK: Indeed that is where  
he works.

THE COMMISSIONER: Yes. That  
is not very far away and I thought perhaps as long  
as he could be available so that if we need him at  
11:30 he can come...

MS. CRONK: I will speak to Dr. Becker.

MR. ORTVED: Mr. Commissioner, I





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have spoken to him and he is available any time.

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THE COMMISSIONER: All right. Thank

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you.

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---Whereupon the hearing adjourned until Wednesday,  
September 21st, 1983 at 10:00 a.m.

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